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ABSTRACT

The report details the background, development, and implementation of a school-community coordinated preschool program for suspected handicapped children under age 5. Legal mandates to identify preschool children with special needs are cited, despite a permissive mandate of serving those identified. Ten steps to be taken by districts in planning for such a preschool program are listed. The following five components of the model are addressed in terms of philosophy and rationale, and strategies for achievement: identification, evaluation, placement, staff training, and parent participation/education. A case study is provided to illustrate the roles played by the school, community, and service providers. Appended material includes lists of resources for identification, evaluation, and placement. (CL)

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A MODEL FOR COMPREHENSIVE SERVICE DELIVERY FOR PRESCHOOL HANDICAPPED CHILDREN

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School-Community Coordinated Services Preschool Project

Cuyahoga County Board of Education,
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FOREWORD

In January, 1979, the Cuyahoga Special Education Service Center, under the auspices of the Cuyahoga County Board of Education, received ESEA, (Elementary and Secondary Education Act), Title IV-C Funds to initiate a School-Community Coordinated Services Preschool Project. The two-and-one-half year research and development project had as its primary goals:

1. To identify effective procedures for the identification and evaluation of suspected handicapped children under age 5
2. To develop eligibility criteria for determining appropriate placement of and related services for preschool handicapped children
3. To identify evaluation techniques and instruments appropriate for the early childhood population
4. To facilitate working relationships among schools and community service providers to expedite effective delivery of service for preschool handicapped children and their parents
5. To develop guidelines for providing information and counseling to parents of handicapped preschoolers
6. To identify mechanisms for preservice and inservice training for professionals who serve the preschool handicapped population
7. To develop a manual which describes procedures for the identification, evaluation and placement of preschool handicapped children and staff and parent education

The procedures for identification, evaluation, and services for young handicapped children and for parent and staff education which are described in this manual were written by Preschool Project personnel, a Consultant Team, and staff of the Cuyahoga Special Education Service Center, with input from parents, medical professionals, and school district personnel. Some of the strategies described in the manual are currently in operation in a number of school districts in various regions in Ohio; others were recommended by consultants and field-tested in one or more of the pilot school districts during the two-and-one-half year project period. The selection of field-test sites was based on the interest and efforts of the school districts in providing comprehensive services to preschool handicapped children. The three pilot subregions and the specific criteria used to identify them are included in Appendix A.

The purpose of this manual is to provide the reader with a variety of different methods for the delivery of comprehensive services to preschool handicapped children and their families. The manual is designed to be used as a guide for school districts as they implement the mandates of P.L. 94-142 and attempt to respond to the needs of young handicapped children.

ACKNOWLEDGMENTS

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PREFACE

Rationale for Early Intervention

There is considerable evidence to suggest that general abilities are not fixed at birth, and that early intervention can and does significantly affect the developmental potential of young children. Investigation of this question has led to two avenues of research, one addressing clearly handicapped populations, and the second focussing on disadvantaged or "at-risk" children. Interventions with handicapped children have demonstrated that early stimulation is related to the eventual integration of these youngsters into less costly regular education programs (Hayden, 1977; Ritchie, 1979). Sometimes even the initiation of intervention programs at age two versus age three can make a substantial difference in handicapped children's eventual adaptation to regular classrooms (Horton, 1974).

Longitudinal studies with disadvantaged populations (Lazar & Darlington, 1978) have demonstrated the lasting benefits to children who were enrolled in early intervention programs. A partial listing of benefits which have been associated with early intervention include fewer retentions, fewer placements in special education, higher scores on reading and math tests, and better social adaptation during adolescence when compared to controls (Lazar & Darlington, 1978; Schweinhart and Weikart, 1980).

It can no longer be assumed that "at-risk" status in infancy, such as low birth weight or birth trauma, for example, will be associated with subsequent learning difficulties. Research has demonstrated that the environment in which children spend their early years is more predictive of their eventual adaptation than these early medical variables (Hartlage and Telzrow, 1981). Such findings are indicative of the importance of utilizing a transactional model in program planning (Meisels & Anastasiow, 1980, in press; Sameroff and Chandler, 1975). This approach incorporated information about the educational/intervention milieu of the child with the evaluation of physical and psychological status during prognosis and program development. We can clearly not predict a child's outcome without careful consideration of the remedial efforts underway.

Need for Comprehensive Service Delivery Model

The legal documents which address the issue of school districts' responsibilities to handicapped children from birth to age 5 present conflicting issues which make clarification of federal and state mandates a difficult task. The P.L. 94-142 requirement that every handicapped child ages 3-21 be served by 1980 and ages 0-21 by 1982 is qualified by the excepting of ages 3-5 (1980) and 0-5 (1982) if the requirement is at variance with state law or practice. Ohio Revised Code requires the provision of special education programs to all eligible children of compulsory school age (3323.04) and authorizes special education programs for children not of compulsory school age (3323.06). Compulsory school age in Ohio encompasses ages 6-18 (3321.01), yet with the mandated provision of kindergarten programs (3311.29)) and the application of Section 504 of the Rehabilitation Act (*Federal Register*, May 4, 1977), Ohio's schools must provide special education for children of kindergarten age (i.e., age 5 by September 30). The provision of special education programs is permissible for children ages 3 to 5 (3323.08 (B1)), and diagnostic and parent counseling services for children under age 3 are authorized (3323.06 (B)).

While service provision to the child under age 5 is permissive, it is clear that school districts are mandated by P.L. 94-142, the Ohio Revised Code, and Standards for Special Education to identify, locate and evaluate all suspected handicapped children ages 0-21. Consequently, school district personnel are faced with the responsibility for identifying and evaluating children they have not typically served in any way. As such, they may be unfamiliar with appropriate tools and strategies, and lack experience in coping with the special conditions associated with very young children. This manual attempts to address these issues, and to describe strategies and techniques which have been identified as the most valid and workable by the "experts": those public school district personnel who have field-tested these procedures. Because provision of preschool handicapped programs remains permissive in Ohio, many school districts are in the conflicting situation of identifying young handicapped children for whom they cannot provide programs. Such circumstances would seem to prescribe a course of action which facilitates identification of handicapped preschoolers, as is mandated, followed by the maximum degree of support to children and families possible within the limits of the law and resources available. The components of such a position would include clear policy statements describing which preschool handicapped children, if any, will be served, and the specific eligibility criteria for these special education programs. This manual addresses these issues and provides sample policy statements and eligibility criteria which might be adopted.

Another step toward resolving the conflict between the mandate to identify and the lack of mandate to serve is the initiation of strong school-community linkages. Few public schools in Ohio are in a position to provide a special education program for every identified handicapped preschooler. However, programs often exist in the community which can provide these services, and by becoming familiar with the range of services offered and communicating this information to parents, school districts can often link parents to supportive programs and facilitate early intervention for children. Strategies for initiating and maintaining school-community linkages are outlined throughout the manual.

Research findings have demonstrated that programs which incorporate a strong parent component produce the most substantial and long lasting gains for children (Bricker and Bricker, 1979; Stone, 1979). There are a number of vehicles for involving parents of preschool handicapped children, whether a district operates a preschool special education program or not. Specific strategies for providing support, information, and education to parents, both in and out of the district, are described in the manual.

Few public school districts have provided services to children under age five, and consequently, it is rare that public school personnel have had training and/or experience in working with very young children. Such circumstances highlight the need for staff development for those personnel involved in diagnostic and remedial programs. The manual lists the competencies recommended for these professionals and describes ways in which professional development can be delivered.

Early intervention with handicapped children presents a new set of challenges to public schools. Professionals must become acquainted with alternative ways of thinking about assessment, about programming, and about the definition of the client. This manual attempts to focus on the central issues relating to early identification, evaluation, and intervention, and to describe effective field-tested strategies at each step of the process. It is anticipated that the **Model for Comprehensive Service Delivery for Preschool Handicapped Children** will assist school districts in their efforts to respond to the mandates for identification and evaluation of suspected handicapped children from birth, and to provide thoughtful, workable alternatives to the dilemma of nonmandated public preschool programs.

PREPARATION FOR MODEL IMPLEMENTATION

Planning for System Adoption

A model is a focussed description of flexible, alternative methods, strategies, approaches, techniques, procedures or practices which are appropriate for implementation by organizations, groups, institutions or systems. This manual describes the **Model for Comprehensive Service Delivery for Preschool Handicapped Children** by offering considerable information about identification, evaluation, placement, staff training, parent participation/education, and school-community coordination. The described procedures are acceptable under federal and state mandates, are supported by research as viable and have been found to be effective by various school districts. Because of the variety of school districts in Ohio, it is likely that districts that utilize the manual will find that some strategies are applicable to their unique settings, while others are not. School personnel are encouraged to adopt those methods most appropriate for their individual communities.

Prior to implementing components of the model, which are described in this manual, a designated administrator (e.g., Assistant Superintendent, Director of Special Education) within the school system should take responsibility for assessing the current status of the district's policies and procedures regarding services for suspected handicapped children under age five. Completion of a Self-Assessment Inventory (See Appendix B) of district policies and procedures can serve as a comprehensive guide for administrators in the evaluation and subsequent improvement of services to handicapped preschoolers. Prior to the implementation of any, or all, of the strategies included in this manual, it is suggested that the following activities be considered by school personnel.

A. *Secure commitments from other administrators and the Board of Education* for support of model implementation. Through meetings and written information, these school district leaders should be oriented to the components of the model described in this manual, and the potential implications for related change in the district.

B. *Inform other district personnel (supervisors, teachers, support staff) of the administrative commitment* to expand the school district's response to the 0-5 age handicapped and solicit their active support in this effort. Staff meetings and newsletters might be appropriate vehicles for sharing information about current district practices, clarifying related early childhood/special education terminology (See, Definition of Terms, Appendix B), and introducing innovative approaches suggested in this manual.

C. *Involve school personnel who have expressed a special interest in early childhood issues* and who appear to be sensitive to the needs of very young children and their parents by soliciting their input on practices that are perceived as viable for the district. This cadre of staff might include kindergarten teachers, psychologists, principals with early childhood backgrounds, home economics teachers, and any preschool teachers who may be employees of the district.

D. *Develop or revise district-wide philosophical and policy statements* which are consistent with the legal mandates in Ohio and accurately reflect the position of the district with regard to identification, evaluation and service to handicapped preschoolers. (See summary of legal mandates and sample statements, Appendix B). These written statements, when made available to parents, advisory committees, agencies, and a wide range of school personnel, will clearly delineate the official stance of the district and facilitate communication around such issues. Periodic review and revision of the statements may be necessary, especially as legal mandates and funding resources change.

E. *Develop and maintain a system of communication with community based agencies and individuals,* such as physicians, hospitals, clinics, social service agencies, public welfare departments, early childhood programs, colleges and universities, and parents, so that all personnel can become knowledgeable of the services provided by these various institutions and cooperative relationships can be initiated. A School-Community Task Force or advisory committee, representative of the groups listed above, is an excellent vehicle for establishing communication linkages on a systematic basis. School districts can initiate such an effort and reap the benefits of community-wide support for future program development.

F. *Apprise parents of preschoolers of available services, established procedures and new developments,* and encourage their input as strategies are being considered. The School-Community Task Force, community based parent groups, PTA Preschool Committees, neighborhood day care and nursery schools, and district-wide newsletters are all revenues for reaching parents of preschoolers.

G. *Establish a long range plan for implementation* which includes the adoption of various practices

and timelines for achieving them. Initially, it is best to focus on those procedures that most closely conform to existing activities in the district, making small alterations where necessary. As success is achieved, it is possible to prepare for the implementation of new practices which may require different kinds of responses by staff. It is important to determine which staff members should be involved in the planning process, and include, when possible, those who will be responsible for implementing the specified procedures. With the assistance of the advisory committee and other internal staff, periodic evaluations of progress should be made.

H. *Establish or revise financial accounting systems to adequately reflect cost effectiveness of identification, evaluation and program delivery services.* The collection of these data from the beginning can provide valuable evidence for continued and increased services to handicapped preschoolers.

I. *Keep constituents (i.e. parents, community agencies, medical personnel) informed of the district's progress in implementing the model* through periodic verbal or written reports.

J. *Share information with and solicit feedback from other school district personnel and regional service centers* regarding successes, as well as problems in efforts to provide comprehensive services to preschool handicapped children. This may be done on an informal basis or through workshop presentations at professional meetings. School psychologists, pupil personnel directors, speech therapists, Child Find Coordinators, early childhood teachers, and parents represent potential spokespersons because of their interest and involvement in a variety of services for young children.

FLOW OF SERVICES TO PRESCHOOL HANDICAPPED CHILDREN

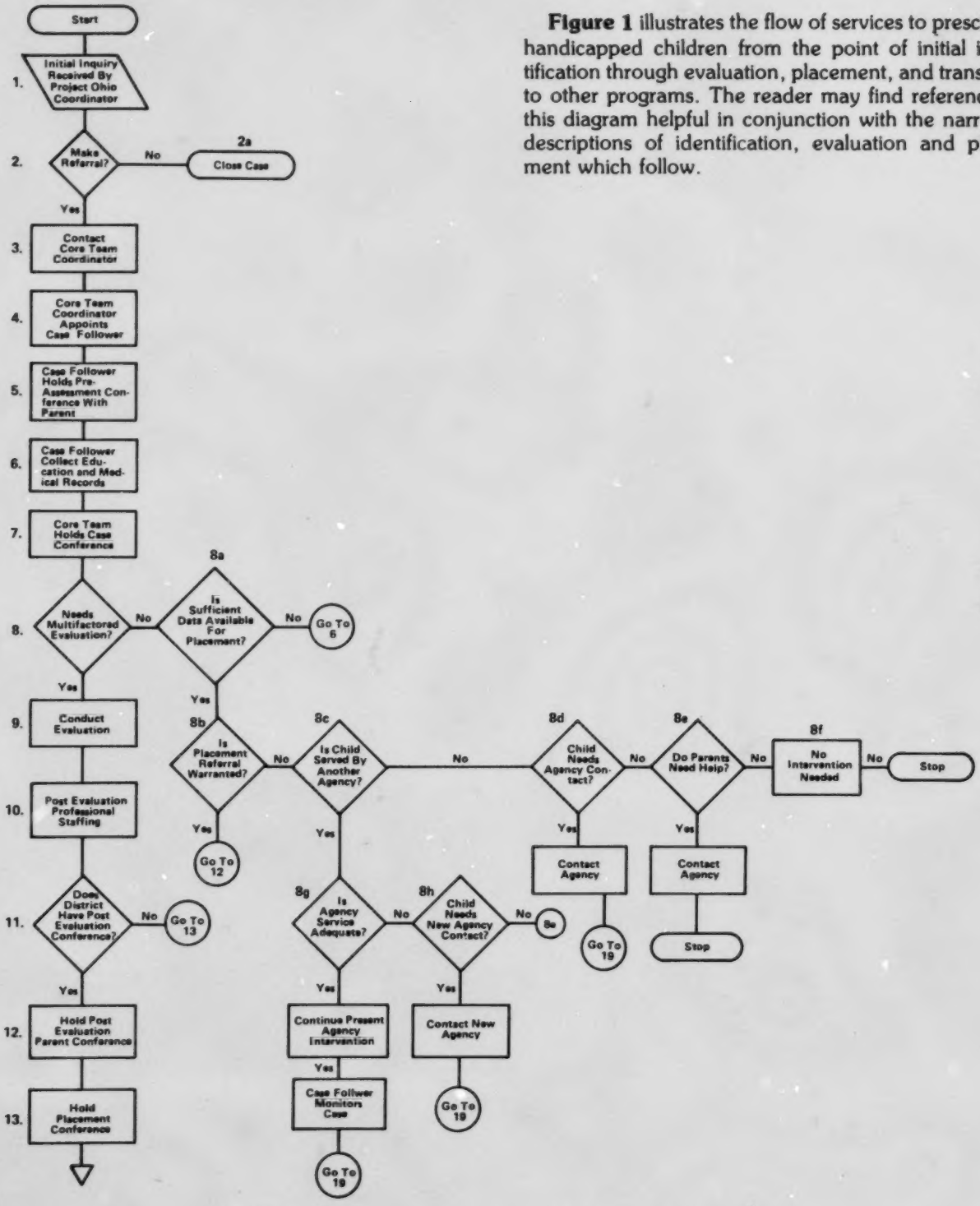
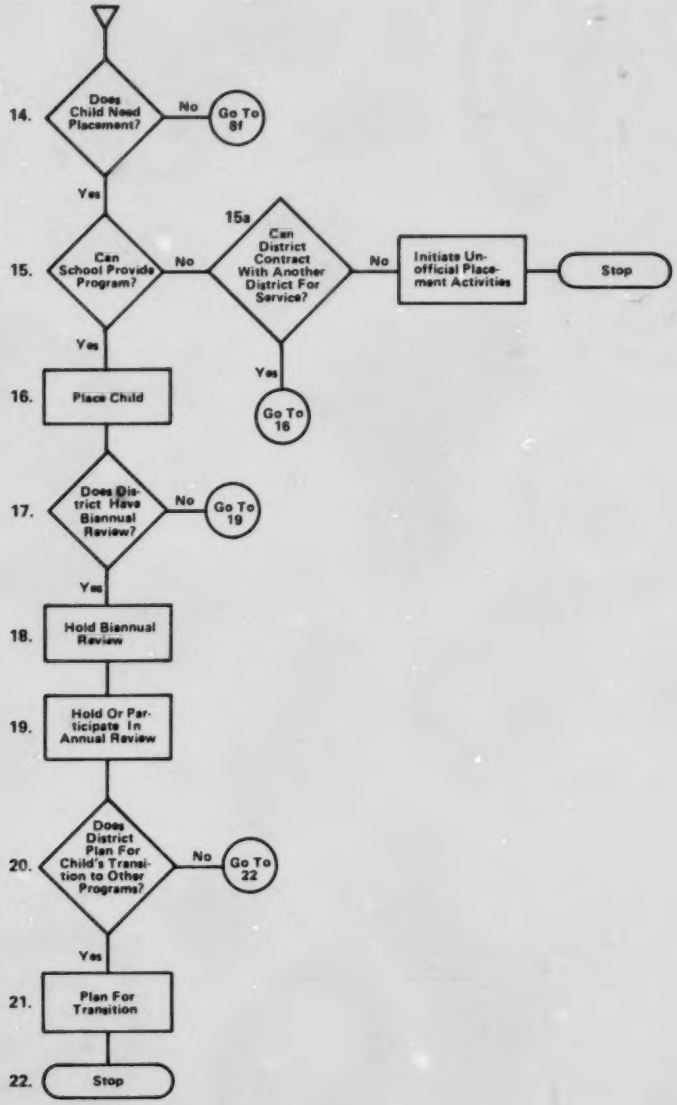


Figure 1 illustrates the flow of services to preschool handicapped children from the point of initial identification through evaluation, placement, and transition to other programs. The reader may find reference to this diagram helpful in conjunction with the narrative descriptions of identification, evaluation and placement which follow.


14.
Does Child Need Placement?
No
Go To 8f
Yes
15.
Can School Provide Program?
No
15a
Can District Contract With Another District For Service?
No
Initiate Unofficial Placement Activities
Stop
Yes
Yes
16.
Place Child
Go To 16
17.
Does District Have Biannual Review?
No
Go To 19
Yes
18.
Hold Biannual Review
19.
Hold Or Participate In Annual Review
20.
Does District Plan For Child's Transition to Other Programs?
No
Go To 22
Yes
21.
Plan For Transition
22.
Stop

IDENTIFICATION

"Early diagnosis is desirable when it leads to prevention, early treatment, or constructive counseling; it is irrelevant if it is purely academic and does not change the course of events; it is harmful if, in balance, child or family reap more disadvantages than benefits"

Wolfsenberger, 1965, p.65

Rationale and Philosophy

A. *Mandates to Identify*

Standards for Special Education (1977) require that each public school district have written policies and procedures for the identification of all handicapped children within its boundaries, including those from birth to age five. Such local efforts are to be coordinated with a state-wide public awareness campaign called "Project O.H.I.O. — Child Find" which is conducted by the Ohio Division of Special Education in conjunction with Special Education Regional Resource Centers every three years. Guidelines for identification of handicapping conditions for the purpose of Child Find and program eligibility under Standards for Special Education (1977) refer specifically to those contained in P.L. 94-142: hearing impaired (deaf, hard-of-hearing), crippled (orthopedically, other health impaired), visually impaired, severe and/or multiple impairments, specific learning disabilities, severe behavioral handicaps, mentally retarded, speech or languaqe disorders. While other children (e.g., the abused child or the disadvantaged child) may be considered potentially at-risk, they are not reported to be handicapped by school districts nor are they eligible for evaluation or service under state Standards for Special Education.

B. *Identification-Service Discrepancies*

Concerted efforts to identify preschool handicapped children must be coupled with thoughtful plans for subsequent action. Some school districts may be concerned about identifying large numbers of handicapped preschoolers for whom no programs exist. There appear to be two responses to such a concern, depending upon the type of handicap. Low-incidence handicaps (including hearing impaired, visually impaired, orthopedically impaired, and multihandicapped) would appear to represent the most clearly identifiable conditions among preschoolers. In addition, typically these are the handicapping areas for which public school programs are available. School districts may elect to provide special education programs for some or all low-incidence handicapped preschool children, since the total number of such children needing to be served is limited, and thus a commitment to serve such children would not appear to be associated with a substantial financial obligation. In addition, research has demonstrated that early intervention in these low-incidence handicapping areas is associated with savings in future educational costs because such children spend fewer years in more costly special education programs. In cases where a policy to provide a free appropriate public education for preschool children with a certain type of handicap exists, the dilemma between identification and lack of services disappears, and active efforts to identify such children would be appropriate and desirable.

Identification of high-incidence (developmentally handicapped, learning disabled, speech or language impaired) handicapped preschool children may require different school district policies and practices, which is entirely within the guidelines of federal regulations relating to services to preschoolers. School districts may elect not to provide an educational program for children with these types of handicaps, although school personnel should be aware that if an educational program is provided for more than 50% of identified preschool children within any single handicapping condition, then all preschool children identified with that handicap must be offered an educational program. When a public preschool program is not provided, it may be desirable for school districts to establish school-community liaisons to link parents to services which do exist for such children who are identified. Mass screening by public school districts to identify children with these types of handicaps probably would not be valid, since there would not be a concomitant intent to provide service.

C. *Demographic Characteristics of Districts*

The identification strategies which are described below are intended to represent a wide range of alternatives from which districts can select suitable approaches. A critical consideration in the selection of approach relates to the characteristics of the individual school district and the geographic region in which the district is located. Large urban districts, for example, may find a rich pool of community resources which routinely identify preschool handicapped children.

In such a situation, the development of strong referral patterns may be preferable to a mass screening effort. A rural district may find a house-to-house canvass impractical, while a small village school district may view this as a most productive Child-Find activity. It is recommended that school district personnel evaluate the identification strategies with district characteristics carefully in mind.

Strategies for Identification

A. *Project O.H.I.O. Child Find*

1. Obtain copy of regional plan for Project O.H.I.O. Child Find from Special Education Regional Resource Center. (See directory in Appendix C).
2. Review regional plan to ascertain what strategies will be undertaken regionally which may identify children within the school district.
3. Initiate additional Child Find activities, where appropriate. Illustrative Child Find activities include:
   a. house-to-house contacts by trained paraprofessionals or parents
   b. publication of notices in community newspapers, school newsletter, or legislative newsletter
   c. distribution of information packets to agencies, medical facilities, Headstart programs, day care centers, and nursery schools
   d. radio and TV spots
   e. contacts with PTA, preschool parents, and other parent information groups
   f. liaisons with other programs within the school district, particularly if the district has Title I preschool programs for children who are "educationally disadvantaged."
4. Prepare Child Find materials appropriate to the preschool population. Child Find materials designed to identify preschool handicapped children should include these characteristics:
   a. the word "handicapped" should be minimized, and, where used, explained thoroughly
   b. important mental and physical developmental characteristics which may indicate a potential handicap might be included to help parents identify the range of normal development
   c. school districts' responsibilities for identification and evaluation are described
   d. parents' rights to confidentiality and due process are explained
   e. telephone number and/or contact person are included

   Sample Child Find materials are described and referenced in Appendix C.

B. *Screening*

1. Preliminary Decisions

   Before school district personnel undertake a screening program to identify preschool handicapped children, a number of preliminary decisions need to be considered. These decisions relate to such issues as the purpose for screening, the personnel involved in the screening effort, and resources (financial and space requirements) various screening approaches require. Table 1 identifies each of these issues, together with decision questions and alternative action strategies.

TABLE 1
PRELIMINARY DECISIONS RELATED TO PRESCHOOL SCREENING EFFORTS

Issues	Questions to be answered	Possible alternatives
a. Purpose	What is the objective of the screening program? What arrangements are planned for identified children?	The section on "Options for Preschool Screening" (Table 2) describes screening approaches which address groups of children who differ on such variables as age, geographic region, and economic status. Advantages and disadvantages of each approach are provided. Decisions about the type of screening to be implemented should include careful examination of Table 2 in conjunction with the school district's purpose for screening. In addition, district policies regarding the scope of services to preschoolers should be formulated prior to the selection of the screening approach.

TABLE 1
PRELIMINARY DECISIONS RELATED TO PRESCHOOL SCREENING EFFORTS
(continued)

Issues	Questions to be answered	Possible alternatives
b. Personnel	Who should be involved? Is there sufficient staff? Will volunteers be needed? Do they need to be trained?	Often screening utilizes a team approach of professionals from various disciplines, under the direction of a team leader. Volunteers, such as parents or PTA members, have been used effectively in screening efforts if appropriately trained.
c. Finances	What are projected costs for equipment, personnel, followup? Is the procedure cost-effective?	Decisions about the screening instruments, personnel, and type of screening selected all impact the total cost figure. A determination about the cost effectiveness of a given approach must be made in relation to the purpose of the screening program.
d. Resources	What is the potential for cooperating with another district or the Special Education Regional Resource Center in shared screening efforts? Would it be worthwhile to contract with an agency to provide screening sources?	Special Education Regional Resource Centers can provide assistance in planning and implementing screening programs. Other sources of help might include public health departments, colleges and universities, health and mental health clinics, hearing and speech clinics, and professional associations.
e. Facility	Where will the screening be held? Is the facility accessible? Is it attractive, safe, and of adequate size?	Sufficient space should permit areas for registration, parent interview, sibling play, screening stations, and separate quiet spaces for hearing, speech, and vision screening. A neighborhood school or center may cooperate by providing a screening facility.
f. Notification	How will the screening be publicized?	Brief, colorful flyers distributed to day care centers, churches, and displayed in doctors' offices, supermarkets, and neighborhood centers are vehicles to publicize the screening effort.

2. Types of Screening

A variety of types of screening are available from which school districts may choose, depending upon the preliminary decisions made. The type of screening approach selected is determined by such factors as the school district's purpose for screening and the resources available for the screening effort. The available screening alternatives, together with the advantages and disadvantages of each, are outlined in Table 2.

TABLE 2
OPTIONS FOR PRESCHOOL SCREENING

Type of Screening	Advantages	Disadvantages
a. Mass screening for total population 0-5	Puts school district in contact with entire population of preschoolers	Expensive Requires extensive publicity May identify many false positives
b. Screening of children at specific ages (e.g., 0-18 months, ages 3-4, kindergarten age)	Systematic	Expensive Overlooks children above and below designated ages

TABLE 2
OPTIONS FOR PRESCHOOL SCREENING
(continued)

Types of Screening	Advantages	Disadvantages
c. Screening by geographic region	Makes mass screening workable for a large district	Requires significant commitment of time, personnel Requires transportation of materials and equipment
d. Screening of agency referrals	Limits number of children screened	Relies on another agency's pre-screening evaluations
e. Screening of children from low-income families	May allow for prevention of subsequent educational failure	Requires economic information about families Overlooks handicaps that are not income related Conveys stigma
f. Cooperative screening with health facility by age (e.g., health facility screens 0-3; school district screens 3-5)	Facilitates cooperative relationships between school district and health agency Reduces costs	Requires interagency cooperative arrangement
g. Home screening	Allows for viewing child in natural environment Permits facilitation of good home-school communication	Time consuming Costly May not permit evaluation of all areas of functioning
h. Kindergarten screening	May prevent school failure by permitting special education intervention	May falsely identify some children who are "shy" or unfamiliar with school situation

3. Screening Instruments

   The selection of screening tools requires a thoughtful match of the school district's objectives for screening and the characteristics of the instruments. The following considerations will influence the choice of a screening instrument.

   a. The Standardization Procedure and Norming Population

      School personnel should critically evaluate the technical manuals of the screening instruments under consideration to determine whether the normative population matches the population to be screened, especially on such factors as ethnic group, socioeconomic levels, geographic region, and age.

   b. Reliability and Validity

      It is important that school personnel are familiar with the levels of reliability and validity which have been reported for the screening instruments, and how these may influence screening outcome. For example, screening devices which have been validated against nonverbal criterion measures may not represent the best predictors of academic difficulty.

   c. Administration Time

      Screening is by definition a brief process, and screening tools should reflect this characteristic.

   d. Purpose for Screening

      The purpose for screening is critical for the decision of selection. A prediction of academic difficulty may be done most effectively by a pre-academic readiness measure, whereas screening for behavior problems may be accomplished most successfully via a teacher or parent checklist.

   e. Screening Personnel

      The number and type of personnel involved in screening may limit the instruments which can be appropriately utilized. Some screening tools specify that only trained and/or certified personnel should administer them, while other screening processes require the involvement of a team of individuals.

f. Facility

Certain types of screening require soundproof facilities, or separate stations, or a place for a quiet parent interview. When selecting a screening instrument, school district personnel need to evaluate prospective tools in light of any constraints in the screening facility.

Table 3 provides a listing of various preschool screening instruments, together with a brief description of each. Readers are referred to such references as Compton (1980), Cross & Goin (1977), Davidson, et al (1977), Davis (1980), Goodwin & Driscoll (1980), Lerner, Mardell-Czudnowski, & Goldenberg (1981), Murray (1980), Pencyna (1980), Sommer & Churton (1978), and Walker (1973) for further information related to screening.

TABLE 3
PRESCHOOL SCREENING INSTRUMENTS

Screening Instrument	Author	Publisher	Ages	Comments
ABC Inventory	Adair & Blesch	Research Concepts	3½-6½	Kindergarten readiness instrument provides readiness age scores. Tasks including drawing and copying, folding, counting, memory, and general information.
Birth to Three Developmental Scale	Bangs & Dodson	Teaching Resources	Birth to 3 years	Provides for early identification of developmental delay in four behavioral categories: oral language (comprehension and expression), problem solving, social/personal, and motor. Provides developmental age scores for each of the 5 scales and a developmental profile. Separate 1-page scales provide for easy usability.
Carolina Developmental Profile	Lillie & Harbin	Kaplan Press	2-5 years	Criterion referenced checklist to be administered by the teacher or another professional. Flexibility in administrative procedures allows expanded use for handicapped children. Administrative methods include observation and structured presentation. Test provides developmental age scores in gross and fine motor, visual perception, reasoning, receptive and expressive language. Designed to assist the teacher in developing long-range objectives to increase developmental skills in these areas. A developmental profile across all 6 skill areas is provided.
Child Behavior Checklist	Achenbach	Child, Adolescent, Family, and Community Psychiatry, University of Vermont, Burlington	4-16	Parent or teacher report format used to obtain a measure of social competence and behavior problems. Mean scores reported by age and sex.
Child Development Assessment Form	McMurrain, Kaufman & Garcia	Humanics Limited	Birth to 3 years; 3-6 years	These two age scales are made up of checklists of selected skills and behaviors designed to be used by teacher or teacher's aide. The 3-6 year old form includes 4 scales: cognitive, social-emotional, motor skills, and self-help. Checklists assist in the observation of behavior and help in the planning of educational activities. Manual is useful for agencies or nursery schools in the development of comprehensive assessment programs.

TABLE 3
PRESCHOOL SCREENING INSTRUMENTS
(continued)

Screening Instrument	Author	Publisher	Ages	Comments
Circus	Anderson, et al	Educational Testing Service	Pre-K to K	Group administered screening instrument to determine school readiness. Includes 17 subtests of academically oriented tasks.
Comprehensive Identification Process	Zehrbach	Scholastic Testing Service, Inc.	2½-5½	Comprehensive screening instrument which determines the need for further evaluation in 8 areas (cognitive-verbal, fine motor, gross motor, speech and expressive language, hearing, vision, social/affective, medical history).
Denver Developmental Screening Test	Frankenburg & Dodd	Ladoca Project and Publishing Foundation, Inc.	1 month-6 years	Four subtests identify developmental delays in these areas: personal-social, fine motor - adaptive, language and gross motor. Responses are scored as normal, questionable, or below normal. Finer discriminations at younger ages. Spanish version available. Original normative sample weighted heavily towards white, middle-class population. Also, children with serious handicaps omitted from original sample. Test materials well constructed. Easy to administer. May discriminate against children from other than white, middle class backgrounds.
Developmental Activities Screening Inventory (DASI)	DuBose & Langley	Teaching Resources Corporation	6 months-5 years	Can be administered by teacher or professional diagnostician. Instructions given visually or verbally. Designed as informal screening measure which taps a variety of skills, including fine-motor coordination, cause-effect, means-ends relationships, association, number concepts, size discrimination, and seriation. Provides a developmental level which may reveal need for further in-depth evaluation. Tasks divided into 9 developmental levels of 6 months each. Manual also provides suggested intervention strategies based on performance. Requires some collection of test materials. Useful as a non-language test (correlation of .19 with REEL and Preschool Language Scale). Good validity and reliability scores.
Developmental Indicator for the Assessment of Learning (DIAL)	Mardell & Goldenberg	DIAL, Inc.	2½-5½	Scaled scores obtained in gross motor, fine motor, concepts and communications to assist in identification of children with potential learning problems. Age cut-off points provided for each subtest to determine need for remediation or retest. Behavioral observations included in test. Some items may be too easy for some 4 and 5 year olds.
Developmental Profile (Alpern and Boll)	Alpern & Boll	Psychological Developmental Publications	6 months-12 years	Test utilizes interview technique to determine developmental competencies in these areas: physical, self-help, social, academic, and communication. Age scores obtained. Useful for screening large populations quickly. Data obtained helpful in developing individual remedial plans. Also provides an adequate measure for evaluating programs with pre and post-test data.

TABLE 3
PRESCHOOL SCREENING INSTRUMENTS
(continued)

Screening Instrument	Author	Publisher	Ages	Comments
Developmental Test of Visual Motor Integration (Beery VMI)	Beery & Buktenica	Follett Publishing Company	3-adult	Screening test of visual motor functioning using copy forms format. Provides visual motor age equivalent scores.
Eliot-Pearson Screening Inventory	Meisels & Wiske	Eliot-Pearson Department of Child Study	4-6 years	Total score obtained indicates need for further testing or referral. Areas tapped include: perceptual, cognitive, language and motor development. Prefer professional diagnostician. Information is used in conjunction with data from health history, parent questionnaire, and hearing and vision tests.
Fairview Behavior Evaluation Battery for the Mentally Retarded	Ross, Boroskin, & Giampiccolo	Research Department Fairview State Hospital	1 month-10 years	Useful for mild, moderate, severe or profound mentally retarded populations to determine age equivalents. Lists tap these areas: developmental, self-help, social skills, language, and behavior. Scoring and administration easy. Designed for the mentally retarded population.
Kent Infant Development Scale (KID Scale)	Reuter & Katloff	Kent State University Press	0-1 year	Parent report scale offers computer scoring. Reports developmental age scores in 5 domains.
Lexington Developmental Scale	Child Development Centers of United Cerebral Palsy of the Bluegrass	United Cerebral Palsy of the Bluegrass, Inc.	11 months-6 years	Provides charted age level for these areas: motor, language, cognitive, emotional, and personal-social development. Useful in charting progress, planning intervention. Inexpensive, yet adequate measure. Available in long or short form. Easy to score. Developmental profile provides easy interpretive technique.
Maxfield Bucholz Scale of Social Maturity with Preschool	Maxfield	American Foundation for the Blind, Inc.	1 month-6 years	Useful measure of social competency for young visually impaired children. Scale evaluates scope of activities in child's everyday life. Sections include self-help, communication, socialization, locomotion, and occupation.
McCarthy Screening Test	McCarthy	Psychological Corporation	4½-6	Six selected subtests from the McCarthy Scales of Children's Abilities used to identify at-risk children. Research to date suggests poor correlation with total McCarthy score. Alternative short forms of McCarthy may be adapted as a screening device (e.g., see Kaufman & Kaufman, 1978).
Minnesota Child Development Inventory	Ireton & Thwing	Behavior Science Systems, Inc.	1-6 years	Provides a comparison of child's development with peers of same age and sex in 8 areas: general development, gross and fine motor, expressive language, comprehensive-conceptual, situation comprehension, self-help, personal-social. Performance scored as normal, 20% below age criteria, or 30% below age criteria. Research finds the MCDI a good discriminator between problem and non-problem children at ages 3-4. Useful for children who may be mentally retarded, physically handicapped, or who may have developmental or language delays.

TABLE 3
PRESCHOOL SCREENING INSTRUMENTS
(continued)

Screening Instrument	Author	Publisher	Ages	Comments
Preschool Attainment Record	Doll	American Guidance Service	6 months-7 years	Rating scale and checklist which may be completed by parent, teacher, or other adult familiar with child in approximately 30 minutes. Useful for children with developmental delays, emotional disturbance, neuromuscular impairments. Items are scored pass, fail, or doubtful. Scores obtained on three scales: intellectual, social, and physical as well as overall attainment quotient. Areas assessed include ambulation, manipulation, rapport, communication, responsibility, information, ideation, and creativity.
Preschool Screening Survey	Beers	Clifford W. Beers Guidance Clinic	3½-6½	Provides age norms to determine readiness in these areas: language-cognition, visual motor conceptualization, visual discrimination, motor coordination, numbers and digit span.
Rockford Infant Developmental Evaluation Scales	Project RHISE	Scholastic Testing Service, Inc.	0-4	Observation and structured items arranged on checklist form. Includes five domains (self-help, fine motor/adaptive, receptive language, expressive language, gross motor). Performance reported in developmental age scores.
Screening Test of Academic Readiness (STAR)	Ahr	Priority Innovations, Inc.	4-6	Group administered screening test which permits screening of large numbers of children for kindergarten readiness.
Screening Test for Auditory Comprehension of Language (STACL)	Carrow & Woolfolk	Learning Concepts	3-6	Screening version of the Test for Auditory Comprehension of Language, developed by excerpting items from the TACL.
The Token Test for Children	DiSimoni	Teaching Resources	4-12	This screening device provides a measure of receptive language capacity. Norms are reported in 6 month intervals.
Verbal Language Development Scale	Mecham	American Guidance Service, Inc.	1 month-16 years	Test utilizes parent or teacher interview to measure child's performance on verbal tasks. Provides a language age equivalent. Adapted from two other tests: the Vineland Social Maturity Scale, and the Utah Test of Language Development, of which this is an interview version. Mother or rater opinion is basis of measure.
Yellow Brick Road	Kallstrom	Learning Concepts	4¾-6¾ years	Screening instrument used to identify strengths and weaknesses of preschool children. Scores are provided in 4 domains (visual, auditory, language, and motor) and total score.

4. Cut-off Scores

Screening is designed to separate those children who have a high probability of demonstrating a handicap from those who do not. The possible outcomes of screening are depicted in Figure 2.

SCREENING DECISION	ACTUAL: Handicapped	ACTUAL: Not Handicapped
Handicapped	Hits	False Alarms
Not Handicapped	Misses	Correct Rejections

Figure 2, Possible Outcomes of Screening

The relative proportion of hits to false alarms is related to the decision (cut-off) criterion established on the screening instrument. A high cut-off will result in a high number of false alarms (children thought to be handicapped who are not), but will probably reduce the number of potential misses (children assumed not to be handicapped who are). A low cut-off will reduce the number of falsely identified children, but may also increase the risk of missing handicapped children. When establishing cut-off criteria, school districts need to do so in light of cost-benefit ratios: a higher cut-off will result in more children requiring subsequent in-depth evaluation. On the other hand, a criterion that is set too low may well allow some children to remain unidentified.

5. Evaluation of Screening

Evaluation of the screening program is necessary for systematic feedback leading to change and improvement. Procedures for obtaining a comprehensive evaluation of the screening program might include:

a. *Questionnaires completed by parents* to evaluate such factors as the receptivity of the staff, publicity for the screening effort, and adequate explanation of screening results.

b. *Critique by screening personnel,* via written form or verbal discussion. Staff comments might be solicited about such factors as scheduling of children, facilities, and recording and transfer of information.

c. *Analysis of hit rate* by school administrators or special education personnel, in which findings from subsequent in-depth evaluations are compared with screening results, would provide information regarding the appropriateness of the established criterion or cut-off score.

d. *Longitudinal follow up of students* via such criteria as achievement and social competency measures would provide predictive validation for the screening effort.

EVALUATION

" Testing a young child is a difficult task even for the experienced examiner and requires special knowledge of children, perceptiveness, and a skillful testing technique"

Kaufman and Kaufman, 1978, p. 7

Rationale and Philosophy

Public school districts in Ohio are mandated by state and federal legislation to provide diagnostic evaluations for suspected handicapped children from birth to age 22. In-depth evaluation may occur as a result of a direct referral from parent, physician, or other professional, or it may follow as a second-stage diagnostic procedure after screening. The evaluation of preschool aged children by public schools presents a special set of circumstances, briefly listed below.

A. *Guidelines for Assessing Preschool Children*

1. Effects of Age and Nature of Handicap

   The diagnostic procedures will vary depending on three variables: age (0-2 versus 2-5), type of handicap (low-incidence versus high-incidence), and severity of the condition. Figure 3 depicts a three-dimensional model of the interaction of these variables. Obviously, a profoundly involved infant with a low incidence handicap would require a different assessment procedure from a four-year-old with a mild high-incidence condition. The former child is more apt to be identified at a younger age, by medical rather than educational facilities. The age consideration is critical, since research has demonstrated that infant performance is not highly correlated with later intelligence test scores (McCall, Hogarty, & Hurlburt, 1972), that there is little variability among individual infants' performance (Scarr-Salapatek, 1978), and that neuromuscular development, such as is often evaluated for infant performance, is an especially poor predictor for handicapped infants (Kearsley, 1981). The development of verbal competence, between the ages of two and three, signals a major shift in cognitive development and measurement strategies.

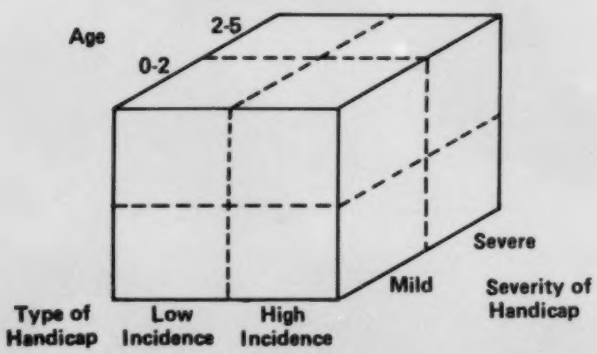


Figure 3. Three-dimensional Model for Evaluation of Preschool Handicapped Children

2. Involvement of Parent

   Evaluating preschool children, especially infants, can often be accomplished more effectively if the mother or another primary caretaker participates in the procedure. This is especially important when working with the 0-3 year old population, where we are not so concerned with readiness for school as with an accurate appraisal of the child's current functioning. The most effective procedure for obtaining a valid measure may be by this cooperative arrangement.

3. Preparation of Child

   Preparation of the child for various phases of the evaluation is an important consideration, especially with regard to unusual types of assessment (e.g., various medical tests). Professionals can offer assistance to parents prior to these sessions so that trauma to the child is minimized.

4. Importance of Observation

   As will be mentioned in detail in a subsequent section, observation of behavior in a variety of settings (parent-child interaction at home or in the preschool between peers, for example) may provide insights to those who are involved in planning intervention strategies.

5. Family-based Assessment

   Because the very young child cannot be separated from the total ecology of the family, recognition of the workings of families is an important factor to be considered by evaluators of young children. Assessment of the child in a natural setting, mentioned above, and observation of the interaction of the child with other family members may provide some insight into the child as a member of the family system.

6. Cooperation with Other Service Providers

   Evaluation of preschool handicapped children must address two clients: the handicapped child and the parent(s). Resources to deal with all the issues presented by both sets of needs (i.e., the child's and the family's) during the evaluation process may not be available within the public school. In addition, public school personnel have not typically had experience in evaluating younger children, and the assessment phase could be enhanced by the expertise of those who have. Recognizing these factors, it is important that public school districts, which are viewed as primary service deliverers,

enter into cooperative and collaborative relationships with other service providers such as public welfare, health departments, mental health organizations, nursery schools, agencies serving specific handicaps, and medical personnel in order to provide vehicles for maximizing evaluation services for young handicapped children and their families.

B. *Characteristics of School District and Client Population*

Several factors will influence a school district's procedures for evaluation of preschool children, including the following:

1. Age of Child and Type and Severity of Handicap.

   Severely involved children may be identified at a younger age by medical practitioners, as contrasted with children with mild, high-incidence handicaps who may be identified only after entering an educational setting. School districts may wish to adopt different assessment procedures based on one or more of the three variables presented in Figure 3.

2. Accessibility of Other Resources.

   A district located in or near an urban center where a number of diagnostic facilities are available may not receive as many referrals for initial diagnostic evaluations as districts without such resources nearby. Districts like the former may receive information about a child who has already been identified and evaluated for action regarding intervention. Thus the district procedure would need to allow for school-community coordination, whereby diagnostic information is transferred to the public school and, where appropriate, utilized by the placement team in development of the individualized education program.

3. Available Personnel in District.

   A large or medium-sized district with adequate support staff, or one which receives comprehensive support services from a county office may be more likely to receive and respond to referrals for evaluation of preschool children.

4. District Policies Regarding Service.

   It has been demonstrated that districts which operate a preschool special education program or agree to financially service identified children in programs operated by neighboring districts receive a greater number of referrals for evaluation of preschool children. Thus the number of requests for evaluation of preschool children may be projected from past referrals and any changes in district policy regarding services to preschool handicapped children.

5. Linkages with Community Service Providers.

   Districts which have established working liaisons with other providers of service to preschool children (e.g., community nursery schools, day care centers, health clinics) would likely receive more referrals for preschool evaluations.

6. Practice of Educational Assessment Project Within Region.

   Some EAPs in Special Education Regional Resource Centers cooperate with school districts to provide assessment services for suspected handicapped preschool children. In such cases, school district personnel would work with the EAP team, whose members may actually conduct the evaluation.

7. Responsiveness to Parents.

   The reputation school districts build as a result of positive responsiveness to parents appears to impact the number of preschool referrals received as well as the image with which parents perceive the school system and its diagnostic personnel.

Strategies for Evaluation

A. *Purpose of Evaluation*

Individual evaluation of preschool handicapped children is generally performed to achieve one or both of the following objectives:

1. To determine whether the child is eligible for and has need of special education and related services
2. To enable professionals and parents to develop intervention strategies (via the I.E.P.) tailored specifically to the child's individual needs

The evaluation strategies utilized depend, among other things, on which of these questions is being addressed.

B. *Diagnostic Personnel*

A multi-disciplinary team, recommended in the text of P.L. 94-142's criteria for multi-factored assessment, is often the best procedure for the

evaluation of preschool handicapped children, since a multitude of professionals in various agencies and medical facilities may be engaged in providing various aspects of total care for the young child and his family.

1. Composition of Multidisciplinary Team

It is recommended that a core team of diagnosticians who represent various disciplines be identified to receive and process preschool evaluations within a school district. The suggested composition of the core team (Figure 4) includes three major disciplines assumed to be primary: school psychology, speech/language therapy, and early childhood education or early childhood special education. It is suggested that the individuals who make up this core team remain consistent, in order to maximize the effectiveness of the evaluation in this highly specialized area, and in order to provide continuity for families during the pre-school years. It is also recommended that the core team be headed by a coordinator who will act as the major conduit of information into and out of the core team. The parent, as Figure 4 demonstrates, will always be included in the evaluation process, and will work closely with the core team. Support team members, who may be school district employees or representatives from other agencies, may contribute to the diagnosis and planning for individual cases. The relationship between the core team and the support team is demonstrated in Figure 4.

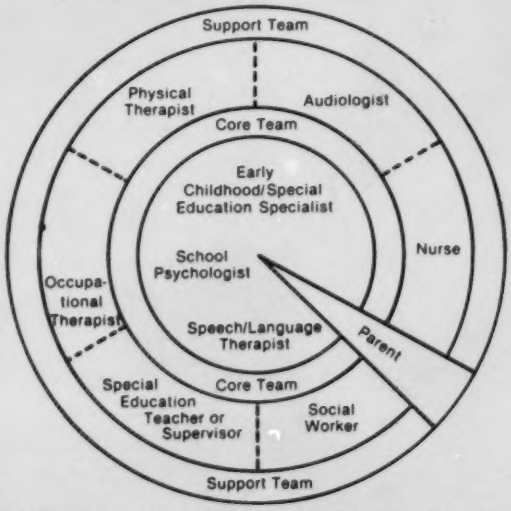


Figure 4. Multi-disciplinary team for evaluation of preschool handicapped children

2. Possible Resources for Support Team Members

Resources for personnel who may contribute to the diagnostic evaluation on the support team are listed below:

In-district Resources

- — special education teacher
- — special education supervisor
- — school social worker
- — school nurse
- — occupational therapist
- — physical therapist
- — audiologist

Out-of-district Resources

- — Educational Assessment Team in Special Education Regional Resource Center
- — Private diagnostic clinic, such as speech and hearing center, health clinic
- — Private physician, audiologist, speech-language therapist, occupational therapist
- — Bureau of Crippled Children's Services
- — Early Periodic Screening, Diagnosis, and Treatment
- — Personnel in Headstart delegate agencies, nursery schools, and day care centers
- — Teachers in community nursery schools and day care centers

C. *Practice of Multi-disciplinary Team*

The activities of the core team are directly related to the comprehensive evaluation of the young child who is suspected of being handicapped. The relationship of the core team to other persons and activities involved in the delivery of comprehensive services to the young child is outlined in Figure 1, *Flow of Services to Preschool Handicapped Children*. The reader may wish to refer to this diagram while reading the section that follows. The specific activities of the core team are described below.

1. Receive all Preschool Referrals.

These referrals may be initiated by parents, professionals in other agencies, a public health nurse, etc. It is expected that all preschool referrals brought to the attention of the Project OHIO Coordinator will be directed to the core team coordinator, who will review referral information and any available evaluation reports and assign one member of the core team as case follower. The case follower will coordinate evaluation activities, make initial contact with

the family, and assure that due process procedures are followed. The case follower's role is critical to provide support and information to families on an ongoing basis, as well as to coordinate procedural activities. It is recommended that the appointment of case follower be done with several considerations in mind, including the match between the presenting problem and the case follower's professional training and expertise. The case follower will act as the parent/family's primary contact person from initial contact onward. If possible, this individual will maintain ongoing communication with the child/family following placement, through annual reviews and reevaluations. Such a practice provides critical continuity for the family and for the child, as someone who has seen him/her over a period of time.

2. Conduct Preassessment Parent Conference

   Initial contact with the family will be made by the case follower and other core or support team members deemed appropriate. The nature and purpose for this meeting may differ according to the referral problems and the family's previous contact with professionals. If the child has been identified as potentially handicapped for the first time as a result of screening, the case follower might talk with the parent(s) about child's development, prepare the parent(s) and the child for the evaluation, and collect behavioral and developmental information. If a child has been previously identified and evaluated by other professionals, the case follower might discuss educational placement options with the parent(s) and receive releases for additional information and permission to evaluate.

3. Request Additional Evaluation Reports

   The case follower will coordinate efforts to obtain other pertinent evaluation reports. Often asking parents to request that such information be forwarded is the best approach.

4. Determine Need for Core Team Evaluation

   Following the preassessment parent conference and receipt of other diagnostic reports, the core team will hold a case conference to determine the need for a multi-factored evaluation. Referring again to Figure 1, it is evident that other actions besides multifactored evaluation may be selected. Especially in cases where existing evaluation reports are comprehensive, the implementation of additional evaluations may be judged unnecessary.

5. Determine Need for Support Team Evaluations

   As they are evaluating the adequacy of previous test results and the findings they can contribute, the core team will determine the need for certain special evaluations which can be conducted by various professionals on the support team.

6. Conduct Multi-factored, Multi-disciplinary Evaluation.

   a. Core team members will conduct individual formal and/or informal evaluations as deemed appropriate.

   b. The case follower will coordinate the support team evaluations by making appropriate referrals and facilitating the implementation of such evaluations via work with the family and the support team member(s).

7. Coordinate Post Evaluation Professional Staffing

   Following the multi-factored evaluation, the case follower will coordinate a professional staffing of core team and any support team members who may be involved. If support team members are unable to participate in the staffing, their evaluation reports will be considered by the core team. During this staffing, team members will:

   a. discuss composite of evaluation results

   b. determine the child's need and eligibility for a special education program

   c. complete an evaluation report for the record and/or transfer to the placement team

8. Communicate Evaluation Results to Parents

   The case follower and other team members as deemed appropriate, will communicate evaluation findings to parents. It is strongly advised that the post evaluation parent conference, where results of the evaluation are explained to the parents, be separated from subsequent meetings where placement and the individualized education program (IEP) are discussed. While scheduling conferences in this way adds an additional step, it permits parents to talk directly with the members of the multi-

factored evaluation team regarding the test findings. In addition, separation of these conferences allows the parent(s) time to reflect on the evaluation report before considering placement and intervention. In spite of this recommendation, it is recognized that logistics make this procedure difficult in some regions, and that as a result, the post evaluation parent conference might include all of the following: communication of test results, recommendations for placement, and development of the individualized education program (IEP).

D. *Components of Multi-factored Evaluation*

A comprehensive multi-factored evaluation, depicted in Figure 5, includes normative, criterion-referenced, and special evaluations. This approach to evaluation permits the evaluators to determine whether or not the child is in need of a special education program, whether he/she is eligible for such a program, as determined by test results and Standards for Special Education (1977), and what specific strengths and weaknesses need to be addressed in the individualized education program.

Figure 5. Components of Multi-factored Evaluation

Type of Test	Definition	Example	Objective	Area(s) of Functioning
Normative Assessment	Compares a child's performance on a standardized instrument with the performance of peers	Intelligence tests Achievement tests Some language and speech tests Some developmental inventories	Responds to the first purpose of assessment: decision of whether or not child is in need of and eligible for special education program	Intelligence, cognitive ability Academic achievement Language and speech development Motor development
Criterion-Referenced Assessment	Provides a description of the child's strengths and weaknesses in the areas assessed	Educational assessment Social competency measures Communicative competency measures Some developmental inventories	Responds to the second purpose for assessment: assists in development of intervention program	Social-emotional development Self-help skills Motor development Language development
Special Evaluations	Provided by specialists who are trained and sometimes credentialled (certified or licensed) to provide them	Neurological evaluation Audiological evaluation Opthamological evaluation	Contributes to both purposes of evaluation: can help clarify diagnostic, eligibility, and intervention questions	Neuroloigical functioning Basic sensory functioning (e.g., hearing, vision)

E. *Resources for Evaluation*

1. Standardized Test Instruments

It is recommended that a minimum assessment battery for preschool children include at least one instrument from each of the functioning areas listed in Table 4, as well as various types of informal assessments. The instruments and strategies listed here are those perceived to be the resources best-suited to a public-school setting. Appendix D includes a more comprehensive listing of assessment tools for use with preschool children. The reader is also referred to other sources, such as Compton (1980), Cross & Goin (1977), David (1980), Goodwin & Driscoll (1980), Murray (1980), Sommer & Churton (1980), and Walker (1973).

TABLE 4
STANDARDIZED TESTS RECOMMENDED FOR USE WITH PRESCHOOL HANDICAPPED CHILDREN

a. *Tests of Cognitive Ability/Intelligence*

Age	Instrument	Comments
0-2½	Bayley Scales of Infant Development	Does not correlate well with IQ at age 6 Scale provides a Psychomotor Development Index and a Mental Development Index (each with mean of 100, SD 16). These scores are **not** equivalent to IQ scores.
2 months-2½ years	Cattell Infant Intelligence Scale	Downward extension of Binet: allows for longitudinal reporting if 1960 Binet forms used.
2½-8½	McCarthy Scales of Children's Abilities	A variety of scores derived, which is useful for diagnosis and intervention General Cognitive Index score considered equivalent to Binet and Wechsler IQ scores LD and EMR populations may obtain significantly lower GCI than IQ scores Inadequate basal for young, delayed children
2-adult	Stanford-Binet	The nature of items (i.e., language versus non-language) varies greatly at the preschool level Use of 1960 and 1975 norms **not** interchangeable
4-6½	Wechsler Preschool and Primary Scale of Intelligence	Limited age range makes longitudinal reporting difficult Inadequate basal for low functioning children at the lower age levels Inadequate ceiling for high-functioning children may limit applicability for gifted children Not interchangeable with Stanford Binet IQ

b. *Tests of Social Competence/Adaptive Behavior*

Age	Instrument	Comments
6 months-7 years	Preschool Attainment Record	Rater scale provides scores on competence in intellectual, social, and physical areas Items may be misplaced according to age levels
2½-5½	California Preschool Social Competency Scale	Primarily teacher-administered, rater must have considerable observation time Provides separate norms by sex, age, and two levels of SES
3-15	The Coping Inventory	Teacher-report or observation used Measures competence in coping with self and environment Provides mean scores for handicapped and non-handicapped children
4-16	Child Behavior Checklist	Parent-report format Measure of social competence and behavior problems Mean scores reported by age and sex

c. *Developmental Inventories*

Age	Instrument	Comments
0-8	Battelle Developmental Inventory	Combines structured items, parent report, and teacher observation formats Includes administrative procedures for handicapped population Reports scores in 5 domains and total score

0-1	Kent Infant Development Scale (KID) Scale)	Parent report scale Computer scoring provides developmental age in five domains Useful for delayed children above one year
0-6	Lexington Developmental Scale	Administered by diagnostician to provide developmental age in five domains Inexpensive, self-contained instrument
1-6	Minnesota Child Development Inventory	Parent report scale, hand or machine score Compares child's development with peers of same age and sex Found to be good discriminator between problem and non-problem children

d. *Speech/Language Tests*

Age	Instrument	Comments
6 months - 6 years	Houston Test for Language Development	Provides a descriptive measure of child's language via observation (up to age 3) Reports communication age in months
2½-adult	Porch Index of Communicative Ability in Children (PICAC)	Provides a measure of communicative competence Child responds orally, with gestures, and by drawing Requires special training for administration
3-7	Test for Auditory Comprehension of Language (TACL)	Measure of receptive language Scores reported in age and percentile scores
4-8	Boehm Test of Language Concepts	May be administered to groups of children Provides percentile scores by SES groupings
3-8	Carrow Elicited Language Inventory	A measure of expressive language and syntactic development Reports standard scores and percentile scores

2. Informal Assessment Strategies

Comprehensive assessment includes several strategies other than the administration of standardized tests. This is especially true for very young children for whom standardized tests may be a poor measure of overall development. The addition of informal assessment strategies contributes to a comprehensive evaluation in several ways. By helping diagnosticians become aware of the impact of the handicapping condition on the child, increased understanding by parents and teachers of related behaviors and emotional reactions is facilitated. Observation, parent report, and other informal procedures also contribute to a realistic appraisal of the child's functioning, which may be underestimated as a result of stress during a structured test procedure. Finally, informal assessment permits a more comprehensive description of the child's current levels of functioning than can be acquired exclusively from normative and criterion referenced tools. To supplement standardized test results, the following strategies for use with preschool children are recommended:

a. *Demographic information*, such as parents' education level or socioeconomic status, has been associated with at-risk status for preschool children.

b. *Developmental history*, obtained from the parent(s) via a structured interview, can provide helpful diagnostic information and clues to remediation.

c. *Observation* of the child in a natural setting (e.g., the home, classroom, playground) allows the evaluator to observe spontaneous incidents which may not be tapped by other devices.

d. *Parent interviews* can provide the evaluator with insights about the child within the family context, leading to important decisions regarding remediation.

e. *Teacher interviews* or checklists are essential components of the comprehensive assessment if the child is enrolled in a preschool program. The information provided by the teacher is especially valuable as it relates to peer relations, group adjustment, and pre-academic skills.

PLACEMENT

"The purpose of any attempt to screen, assess, or identify handicapped individuals is not to label or to set apart any individual as being different from other individuals. Rather, the purpose is to determine those who may need special services so deficits that may limit the attainment of their full potential can be prevented or remediated as fully as possible."

Hayden & Edgar, 1977, p. 67

Rationale and Philosophy

The P.L. 94-142 requirement that every handicapped child ages 3-21 be served by 1980 and ages 0-21 by 1982 is qualified by the excepting of ages 3-5 (1980) and 0-5 (1982) if the requirement is at variance with state law or practice (*Federal Register*, August 23, 1977). Ohio Revised Code requires the provision of special education programs to all eligible children of compulsory school age (3323.04) and authorizes special education programs for children not of compulsory school age (3323.06). Compulsory school age in Ohio encompasses ages 6-18 (3321.01), yet with the mandated provision of kindergarten programs (3311.29) and the application of Section 504 of the Rehabilitation Act (*Federal Register*, May 4, 1977), Ohio's schools must provide special education for children of kindergarten age (i.e., age 5 by September 30). The provision of special education programs is permissible for children ages 3 to 5 (3323.08 (B)), and diagnostic and parent counseling services for children under age 3 are authorized (3323.06 (B)). Because provision of direct program service for preschool handicapped children remains permissive, there will be inconsistencies between and within districts regarding which preschool children, if any, are provided a free appropriate public education.

Official placement activities concerning preschool children would only occur in the context of provision of a free appropriate public education. That is, only when a school district provides a special education program, either within the district of residence or by cooperative arrangement with another public school, are official placement activities (e.g., recommendation for program, development of IEP) appropriate. However, it is anticipated that preschool handicapped children will be identified and evaluated for whom official placement activities are not implemented, since it is unlikely school districts in Ohio will provide special education programs and/or related services to every identified and eligible preschool child. It does appear that there are appropriate legal and ethical positions which school districts can adopt in cases where a preschool handicapped child is identified, but for whom a public special education program is not provided. The following section includes a description of activities in both these categories — official placement and identification without official placement.

Strategies for Placement

A. *Formation of Placement Team*

Federal regulations pertaining to handicapped children (*Federal Register*, August 23, 1977) specify that the decision about placement of handicapped children shall be made by a group of persons who are knowledgeable about the child, the evaluation findings, and the placement options. Ohio Standards for Special Education (1977) indicate that the chairperson and members of the placement team "shall be designated by the superintendent of the school district of residence" (p. 97). These standards further define "placement team" as a "group of multi-disciplinary staff persons organized for the purpose of reviewing information regarding individual handicapped children and making recommendations regarding the most appropriate educational program placement for the child" (p. 70). Referring once again to Figure 1, *The Flow of Services to Preschool Handicapped Children*, it is recommended that the placement team convene in a placement conference following the post evaluation parent conference. During the placement conference, members of the placement team will conduct the following activities:

1. Review the evaluation team report developed by the core and support team members
2. Consider the school district policies for providing a special education program and/or related services for preschool handicapped children
3. Evaluate the evaluation team report in light of specific eligibility requirements and school district policies, and determine
   a. Whether or not the child is eligible for and in need of a special education program. This determination will be made based on the Ohio Standards for Special Education (1977) and specific eligibility criteria established.
   b. Whether or not an appropriate public special education program is available, either within the school district, or through cooperative arrangement with another public school or County Board of Mental Retardation.
   c. Whether or not the provision of such a program is within the approved procedures and practices of the school district

If the placement team determines that the child is eligible for and in need of a special education program, that such a program exists, and that provision of such a program is permitted by the policies of the Ohio Department of Education and the local board of education, then official placement ac-

tivities are pursued. If the outcome of any three of these decisions, just listed is negative — that is, if the child is either not eligible, or if no public preschool special education program exists, or if the school district does not provide special education programs for preschool children — then an alternate course of action is in order.

B. *Official Placement Activities*

Once the placement team has determined that the preschool handicapped child is eligible for and in need of a special education program, that an appropriate special education program is available and that the district can provide such a program within the district of residence or by cooperative arrangement with another district or County Board of Mental Retardation, it is recommended that the placement team

1. Conduct official placement activities as prescribed by Ohio Standards for Special Education (1977), and
2. In conjunction with the parents, develop the individualized education program (IEP).

Placement of preschool children in special education programs involves a unique difficulty not found in placement of school aged children. Because the law does not require the involvement of the district of residence in the placement of children until they reach school age, it is not unusual for preschool aged children to be enrolled in special education programs without notification of the district of residence. This is especially true when programs are operated by agencies other than public schools. Because failure to notify and/or involve the district of residence in the special education placement presents a number of potential disadvantages to long range comprehensive planning for young children, the following practices are recommended:

1. School districts and County Boards of Mental Retardation which operate programs for preschool handicapped children, and which receive students from other districts either on a cooperative or private tuition basis, are encouraged to routinely obtain a release of information to notify the district of residence when a preschool handicapped child has been identified.
2. School districts which have policies to provide service to some or all identified preschool handicapped children, upon notification of the identification of such a child, are urged to become involved with the receiving district or agency in the placement decision.
3. School districts which do not provide services to any preschool handicapped children, upon notification that such a child has been identified and/or is receiving services elsewhere, are encouraged to register the youngster in their Case Information Management System. In such cases, the receiving district or agency may choose to accept the child on a private tuition basis if they so desire.

C. *Special Considerations in Placement of Preschool Children*

Placement decisions are rarely easy, but when they involve preschool aged children, they are complicated still further. The following section discusses special considerations related to the placement of preschool handicapped children.

1. Least Restrictive Environment

"Least restrictive placement" means that "to the maximum extent appropriate, handicapped children . . . are educated with children who are not handicapped." (*Federal Register*, August 23, 1977, p. 42497). Achieving LRE for preschool children is complicated by the fact that regular education preschool programs are rarely available in the public school setting. Therefore if a child is placed in a public school special education program, interaction with same age non-handicapped peers in school is rarely possible. Such a circumstance leaves placement team members with the often unpalatable choice between a full-time special education program and no special education services whatsoever.

"Mainstreaming" for preschool children often means attending a regular nursery school or day care center. Such exposure has been shown to work effectively for large numbers of preschool handicapped children (e.g., see Blacher-Dixon & Turnbull, 1979), and some nursery school settings (e.g., Headstart) have made special efforts to train staff members to understand and work effectively with young handicapped children. It is clear that successful placement of preschool handicapped children into regular education programs must be accompanied by a great deal of prior and ongoing planning and adjustment (Guralnick, 1978).

In determining appropriate placement of

preschool handicapped children, school officials need to evaluate the continuum of available options in light of the least restrictive alternative requirement. Further discussion of the range of LRE alternatives is included in Section F, *Establishing New Placement Options*.

2. Involvement of Parent in Placement Decision

   Although the participation of the handicapped child's parent(s) in the placement decision is generally practiced in most school districts, the nature of this involvement is especially critical when the placement concerns a preschool child. Parents of very young children are still in the initial stages of adjustment to having a handicapped child. Such circumstances require special sensitivity on the part of the professionals who suggest special education placement. In addition, this initial experience with the public school serves to set the stage for future perceptions of the school setting by parents. A pleasant experience will result in grateful parents who are supporters of public education. On the other hand, parents who have felt underinformed, overlooked, or insensitively treated, may be biased against any future dialog with school officials.

3. Match Between Program and Family Characteristics

   Because of the inherent involvement of parents with their young children's educational programs, a thoughtful match between the format of the program and various characteristics of the family are especially important. For example, the provision of transportation might be viewed as essential by some parents. A parent-centered program may be desirable for non-working parents, or those for whom another caregiver can participate, but inappropriate for other families. Liaisons and transportation between the educational program and a day care facility may be necessary for working parents. In short, preschool children — whether handicapped or nonhandicapped — are educated in a wide range of settings. Parents of nonhandicapped children take their own needs and the child's into consideration when selecting an appropriate educational setting. It is important to do this for handicapped children as well.

4. Related Services

   When the placement team has agreed that placement in a special education program is too restrictive, but that some services are appropriate, the provision of such related services is permissible under Ohio Standards for Special Education (1977). In such a case, an individualized education program; developed with the parent(s), would specify the need for and delivery of these related services. Examples of services which may be provided are transportation, speech therapy, and occupational therapy.

D. *Follow-up to Official Placement*

   Special education intervention with preschool children requires a somewhat more sensitive system of monitoring than that prescribed in federal and state guidelines, which were for the most part developed with older children in mind. The following recommendations are made with regard to follow-up with preschool children.

   1. Annual Review

      An annual review of the IEP and placement may not be sufficient for very young children who sometimes demonstrate dramatic gains once intervention programs are initiated. It is recommended that school districts adopt special follow-up/review policies for their preschool children to provide for review at least twice annually, approximately every 4-6 months.

   2. Reevaluation

      A three year reevaluation, prescribed in Ohio Standards for Special Education (1977), while satisfactory for older children, is not considered appropriate for very young children. The positive effects which can occur as a result of intervention programs, and the nature of preschool assessment would seem to support the suggestion for more frequent reevaluations. It is recommended that school districts adopt a policy requiring annual reevaluations for preschool aged children.

   3. Transition to Other Programs

      Preparation of child, parent, and staff for transfer from one program to another is especially necessary for preschool children who may have fears and anxieties not evident in older children. Preparation is necessary prior to initial entry into a special education program, whether from a home setting or a community nursery school. Such preparation may involve a "staggered entry" procedure in which

new children enter gradually over a two or three week period, or limited attendance, ideally with parent present, during adjustment to the program.

The adjustment of children is also important when considering placement after the preschool special education program. It is recommended that staff in the preschool special education program play a substantial role in developing a program recommendation, since they may be best informed about the child's progress. It is also suggested that these individuals may be instrumental in providing liaison services to help prepare teachers for new pupils, as well as to assist children in the adjustment to a new program.

E. *Alternatives to Official Placement*

The proportion of identified preschool handicapped children who will be provided a public special education program in Ohio is likely to be smaller than those who will not be provided such a program. However, school districts can respond to this category of preschool handicapped children in other ways. Specific strategies for response are suggested below.

1. Clarifying Eligibility Criteria

   School districts are mandated to identify and evaluate suspected handicapped children from birth, which includes communicating to parents whether the child is eligible for and in need of a special education program. In the case of preschool children, where the provision of program is permissive, school personnel must still address the eligibility question. It is suggested that specific eligibility criteria, based on the Ohio Standards for Special Education (1977), be communicated to parents prior to and again following the evaluation. A sample of specific eligibility criteria for a preschool special education program for multi-handicapped children is included in Appendix E.

2. Communicating with Community Preschools

   School districts should establish and maintain communication with community nursery school, day care and Headstart directors regarding suspected and identified handicapped children. The district's Project O.H.I.O. Coordinator is one staff person who might take responsibility for this liaison, which will facilitate the informal referral of children who are in need of a special education program. In addition, this arrangement can provide support to these professionals, thereby allowing some children to be served in less restrictive, more appropriate settings than may be available in special education programs.

3. Maintaining List of Resources

   It is suggested that districts maintain an updated list of community resources (e.g., medical facilities, physicians, therapists, mental health centers, Department of Health, Department of Welfare, Bureau of Crippled Children's Services) to which children may be referred for services and from which parents/families may receive the necessary support and counseling. Rarely do school districts have personnel who can respond comprehensively to all needs of the family and the child, and a cooperative arrangement with appropriate community service providers is an alternative to this dilemma. Sharing information about these community resources with other staff members who are involved with the preschool population, such as teachers, administrators, and diagnostic personnel, will improve their helpfulness to parents. In addition, clearly defined procedures for accessing resources are necessary to facilitate service delivery.

4. Developing Cooperative Relationships

   School districts may also wish to initiate cooperative relationships with community agencies that go beyond the methods of information exchange described above. For example, forms may be drafted by the district to be used by agencies in making referrals, or formal agreements/contracts may be entered into for the provision of evaluation services. A copy of such a referral form is included in Appendix E.

F. *Establishing New Placement Options*

In many districts, publicly funded preschool handicapped programs are not available, and community programs may be either filled or inappropriate for the specific kinds of children needing service. This model was not designed to advocate for or against the establishment of preschool special education programs by school districts. It seems imperative, however, that some reference be made to this issue in order to better assist those districts seeking to develop new placement options which avoid duplication of services, are cost effective,

and provide intervention strategies that effectively meet the needs of identified preschool handicapped children.

1. Developing a Single Program Within the District

   a. *Define the problem* by collecting data which answer the following questions: Are there handicapped preschool children within the district who are not being served in any kind of program? How many are there? What is the nature of their handicapping conditions? What are the special needs of these children that prevent them from being served in existing community or school programs? Would the addition of a preschool program solve the current problem of these unserved children?

   b. *Explore alternative strategies.* Examine community resources in light of their adequacy to potentially serve the defined target population. Are the agency programs filled, non-existent or inappropriate for the defined population? Research other school district preschool programs. Are they appropriate for and accessible to this population? Gather information for the State Education Agency regarding any problems experienced by other districts serving a similar population, and follow-up with a direct contact with each regarding their experiences.

   c. *Consider the advantages and disadvantages of various program options.* Examples of the program options to be considered are:

      (1) *Segregated vs non-segregated programs.* Preschool handicapped children are usually served in public school programs that are segregated settings. Most non-handicapped preschoolers are enrolled in non-public programs such as community nursery schools, day care centers or Headstart. One of the major exceptions, however, is the Title I Child Development Programs for educationally disadvantaged 4 year olds. Consequently, few public school options exist for the appropriate placement of handicapped preschoolers who could function in a less restrictive environment than characteristic of a segregated special education program. Because of the categorical nature of funding for special education, handicapped preschoolers are very likely to be placed in programs with other handicapped children. One excellent variation of the typical mainstreamed classroom (handicapped child integrated into a setting primarily designed for non-handicapped) is the reverse mainstreaming approach. Public special education programs could be opened to a limited number of non-handicapped preschoolers. This approach has been successful in a small number of community and university based programs throughout the country (e.g., Bricker & Bricker, 1973).

      (2) *Regular class with supplemental services vs special class.* Although this represents one option in a continuum of services for school agers, it is usually not available to preschoolers whose "regular" class placements are likely to be in non-public rather than public school programs. A district might consider providing supplemental services to such children enrolled outside the district.

      (3) *Home-based vs center-based programs.* The major focus of each of these programs is somewhat different. In the home-based program, the parent is trained to be a more effective teacher of the child (usually below 3 years old) who is not enrolled in a preschool program. In another model of the home-based program, personnel work with the child in the home. Because these approaches require a high level of parental commitment and focus primarily on the parent, they have not typically been used by school districts to impact the child. Center-based programs, described below, may have greater appeal.

      (4) *Home/center-based programs.* The most successful models of early intervention seem to be those which train parents and integrally involve them in the intervention effort, and which link parents to the other major agents of child services and socialization (e.g.,

the school system, medical agencies). The advantage of this model is that it incorporates parent involvement into a child-focussed program in which the child attends the center-based program and teaching techniques are modeled by the staff for the parent in the home situation.

d. *Select a program alternative* that best corresponds to direct needs as determined by:
   (1) characteristics of the children to be served (i.e., age, degree and type of handicap)
   (2) geographical location and density of population (i.e. urban, rural, suburban)
   (3) statement of goals and specific objectives (what the district can reasonably expect to accomplish)
   (4) financial resources available to the district for initiation of a program
   (5) available personnel, support services, and material resources for technical assistance
   (6) state legislation which mandates certain services for specific client groups and therefore plays a role in establishing district priorities. In addition, the categorical funding of special education programs may preclude certain innovative approaches which involve serving preschoolers on a non-categorical basis.
   (7) expectations of constituents in the community regarding the selected program alternative. (Positive school/agency relationships might serve to close the gap between expectations and reality).

e. *Choose an appropriate curriculum*. This is perhaps the most difficult task of all in establishing new placement options, primarily because of the large number of curriculum models and individual variations that have been successfully utilized throughout the country. The appropriate early childhood/special education curriculum for a newly developing program should
   (1) be chosen with extreme care and be consistent with the philosophy of the district and individual personnel to be employed in the program
   (2) have a clearly stated purpose with long and short range goals
   (3) be based on a widely accepted and respected rationale, theory or philosophy of child growth and development
   (4) be designed to effectively meet the individual needs of young children
   (5) be easily implementable with methods clearly defined
   (6) delineate content areas and specific examples of activities necessary to reach the goals

   This manual does not purport to comprehensively describe the number of curriculum models that exist and the theoretical bases of each; instead, references for further investigation have been included in Appendix H. Although a visitation to several projects utilizing models of interest to district administrators may be costly, these trips may be worth the investment of time and money to gather greater insights into the feasibility of the models under consideration.

f. *Involve others in the planning*. Throughout the planning and implementation of a new preschool program, district decision makers, school personnel, and community representatives must be kept informed and given opportunities for input. This total process is similar to that utilized by administrators in implementing the model described elsewhere in this manual.

g. *Evaluate program components*. Because of the current emphasis on accountability, school districts need to collect and maintain data on all aspects of the program (e.g., child progress and long term impact of program, cost analyses, attainment of goals). At some point, these data may provide the necessary documentation needed to substantiate program continuation and expansion.

2. Developing a School/Community Cooperative Program

   One alternative to starting a totally new special education preschool program involves a formal

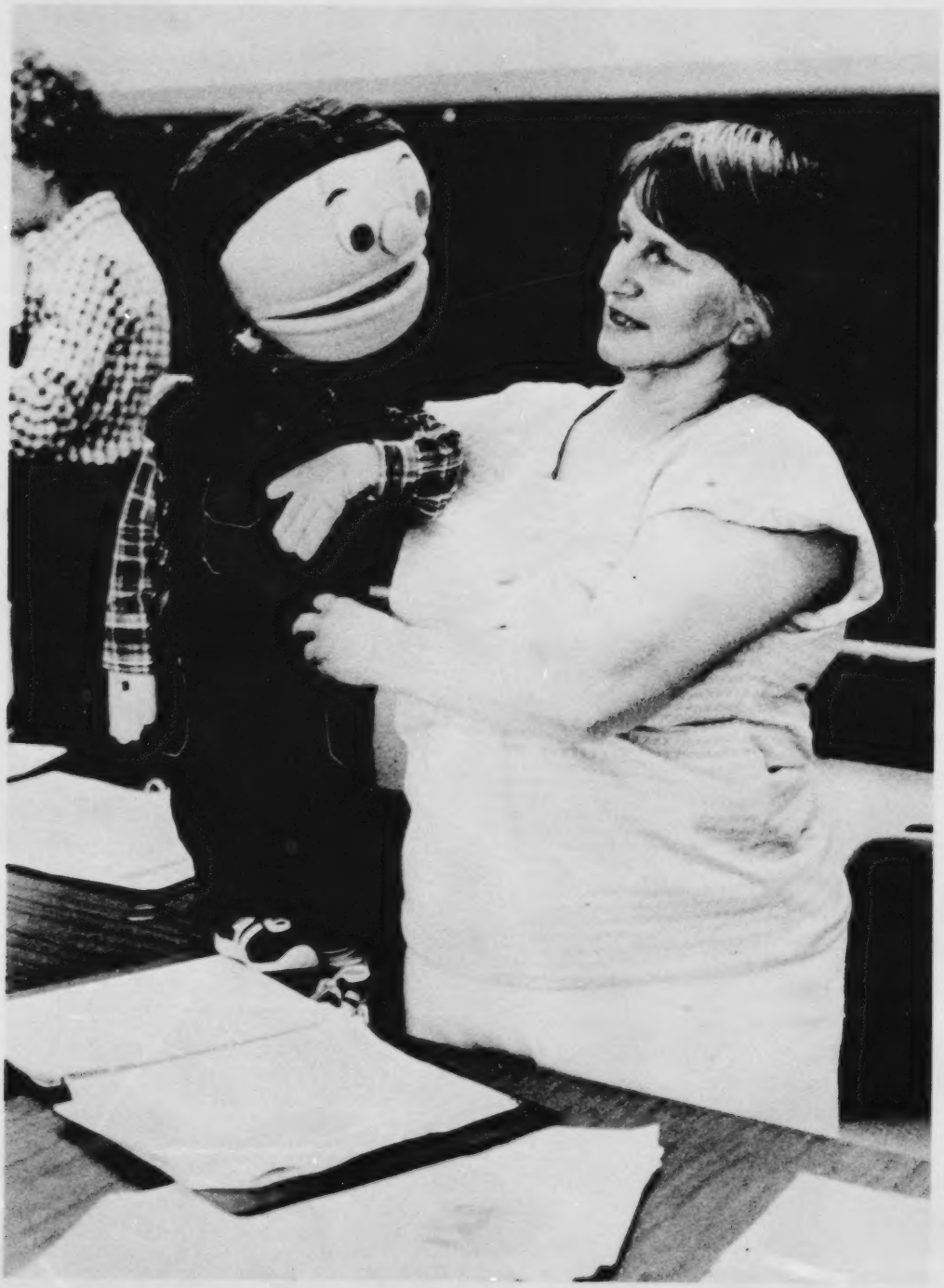
linkage with a private non-profit community agency. In this program option, a district, recognizing the special expertise of an existing community agency serving handicapped preschoolers, (e.g., United Cerebral Palsy) may choose to enter into an arrangement in which the agency's preschool program is fiscally supported by public school funds (e.g., state foundation units, preschool incentive grants, or flow-thru funds) and administered by the board of education. This option maximizes the advantages of both community and school resources, and avoids duplication of services for a particular exceptionality or geographical area. Both school and agency strengths are brought into complementary relationships. For example:

a. The public school
   (1) is the only tax-payer supported educational institution that impacts children throughout the developmental stages and can assure continuity of services and follow-up.
   (2) has developed a standard of excellence for personnel and physical facilities.
   (3) has personnel and assessment mechanisms in place.
   (4) has a financial accounting system to facilitate the documentation of program cost and effectiveness.
   (5) has administrative structures to support the program.

b. The agency
   (1) has a long successful history of working with handicapped preschoolers.
   (2) has established rapport with parents.
   (3) has staff (e.g., occupational therapist, physical therapist, speech therapist, social worker) who can provide supportive services to the education program.
   (4) may be more likely to have an accessible facility with specialized equipment and appropriate materials.
   (5) is recognized as a viable service option by the community (e.g., medical practitioners, social workers).

In conclusion, for preschoolers diagnosed as handicapped, there are numerous placement options from which a school district may choose. Both official placement activities, as well as alternatives to official placement, must be considered carefully so that the most appropriate educational environment is accessible to the preschool handicapped child.

STAFF TRAINING



"Previous efforts to improve job performance concentrated on overall deficiencies (deficit model); now training programs focus on the strengths and competencies of individual staff members as well as on those of the service-family-community team."

Haupt, 1972, p. 111

Rationale and Philosophy

The staff training component of the manual includes two central issues: selection of new staff members and providing staff development for current employees

The first issue is problematic in Ohio, and school districts that have made a commitment to serve preschool handicapped children may find the search for ideal personnel to staff these positions a difficult task. Because the Ohio Department of Education does not recognize certification for either early childhood education or preschool special education, there are few professionals with the comprehensive range of skills such certifications imply. A greater number of appropriately trained professionals may be available in the future as some Ohio colleges and universities have recently developed, or are in the process of developing, early childhood/special education training programs despite the lack of Ohio Certification Standards. Currently most districts staff their programs with individuals who have training and certification in either elementary education or special education, neither of which encompasses all relevant areas required to serve handicapped preschool children and their families. In a few instances districts have been fortunate enough to attract applicants for early childhood special education positions from states offering the desired certification or have utilized a team teaching model, combining an individual certified in elementary education who has extensive experience in preschools with a certified special educator. Until early childhood/special education certification is a reality in Ohio, school districts must utilize other criteria for the selection of appropriate staff and must develop a range of on-going staff development mechanisms to respond to identified training needs of these personnel.

Staff development for early childhood special education personnel is the second issue addressed in this component of the manual. Often school districts direct currently employed personnel into newly created positions when initiating such programs, and inservice training can assist in providing these individuals with expertise in the appropriate areas. The delivery of such specialized staff development programs presents a special set of difficulties for school districts. Because of the small number of staff members involved in early childhood special education, it may be costly and impractical for school districts to design and implement large inservice training programs exclusively for these personnel. However, it may be possible to pursue cooperative staff development with neighboring districts, with local colleges or universities, or via professional organizations in order to meet the individual training needs of such staff members. Vehicles for establishing such procedures are described in this component of the manual.

Strategies for Hiring Appropriate Staff

School district administrators and boards of education will need to be especially mindful of the process for assessing the skills, knowledge and attitudes of prospective staff members when making staffing decisions for preschool handicapped programs. The following suggestions may serve as helpful guidelines for securing staff who can bring the early childhood/special education perspective that is desired to the program:

A. *Post notices of job openings* in local community day care centers, nursery schools, colleges and universities which offer both early childhood and special education curricula, agencies serving handicapped children, the school district, and Special Education Regional Resource Centers. Often individuals who have degrees in education may be currently working with very young children in non-school settings and certification may be a minor process.

B. *Review resumes, transcripts, and other information about professional training* which can be utilized in the assessment of an individual's competency prior to the interview phase. Individuals who have not been exposed to nor demonstrated competency in basic early childhood and/or special education concepts can be eliminated at this stage if so desired.

C. *Note the individual's experiences in early childhood and special education.* Field placements and former employment can provide valuable information about the competencies of individuals who will staff preschool handicapped programs. Administrators may be especially interested in interviewing candidates who have had direct experiences with very young children, as well as familiarity with various types of handicapping conditions.

D. *Rely on recommendations for further insight into the individual's skills.* Letters of recommendation can assist in the selection process. Of particular interest are letters about experiential situations such as field placements and former jobs. References to the quality of the individual's work should be reviewed carefully.

E. *Request an analysis of competency by previous employer.* Administrators may wish to seek the help of a former employer of a prospective staff member to assess the candidate's specific com-

petencies. A questionnaire can be used to structure a telephone conversation or can be sent to the previous employer (see example in appendix F).

F. *Observe prospective employee in current job.* It may be possible for a school administrator to observe a candidate in the current work setting, or perhaps in the setting for which the candidate is being considered. This may be especially desirable in cases where other experiential information may be limited.

G. *Administer self-assessment inventory.* Candidates may provide an accurate assessment of their own levels of competency in various areas. A self-assessment inventory can be completed by the prospective employee or can be used as the basis of the initial structured interview. (See example in Appendix F).

The selection of appropriate personnel to staff early childhood special education programs is a difficult process because of the lack of clearly delineated training programs in this field. The procedures described here can provide school administrators with some mechanisms for contacting personnel with appropriate backgrounds who may be employed in non-school settings, and in ascertaining individuals' level of competence for employment in early childhood special education programs. It is suggested that individuals who have formal training and experience in early childhood education can generally acquire the necessary information and expertise in special education somewhat more easily than special educators can adapt to an early childhood setting. The training and experience of early childhood educators focusses on the needs and issues of young children, and such an orientation provides a valuable foundation for professionals in early childhood special education settings. Handicapped preschoolers, our experience has demonstrated, are children first, and educators who are oriented to such an approach are most comfortable in early childhood special education settings.

Strategies for Delivery of Inservice Training

Procedures and personnel responsible for staff development vary considerably from district to district, but a common objective exists in all settings: the provision of up-to-date, quality information and experience for all staff members. It is recommended the individual most qualified to plan and program for inservice training for personnel in early childhood special education programs is the administrator directly responsible for the programs. This person has the dual advantage of being knowledgeable of the field as well as capable of negotiating with higher level administrators for release time, consultants, and other provisions for the implementation of staff development programs. It is to this administrator that the strategies which follow are directed.

A. *Determine Training Needs*

1. *Identify the staff who are to be involved* in any way with the early childhood special education program. The following individuals are examples of persons who may be included in the staff development programs.
   a. Teachers in special preschool programs designed to serve young handicapped children
   b. Teachers in regular nursery school programs where handicapped children may be mainstreamed
   c. Aides to teachers in specialized preschool programs
   d. Aides to teachers in regular preschool programs
   e. Specialists involved in the evaluation and/or therapeutic interventions of young handicapped children (e.g., psychologists, speech therapists, occupational therapists, physical therapists)
   f. Administrators of specialized preschool programs or in buildings in which these programs are housed
   g. Administrators of regular preschool programs in which handicapped children may be mainstreamed
   h. Additional support personnel: bus drivers, other specialized paraprofessionals
2. *Develop a set of competencies* that can be used as a checklist of criteria for assessing the "entry" level of staff, determining training needs, implementing staff development activities, and evaluating progress toward identified goals. In order to be useful, the listed competencies in a competency based training model must be specific, observable, and measurable. They must also be reviewed periodically and changed if inappropriate (See Appendix F for examples). In developing competencies for assessment, personnel may wish to solicit input from agencies and community

preschools currently serving the handicapped preschool population for their recommendations.

3. *Clarify the level of competencies* expected for any specific group of staff. Because the staff members have different responsibilities and will have varying degrees of involvement with the program, children and families, all personnel should not be expected to function at the same level of competency. One way of conceptualizing various levels of competency involves a three-level system, from lowest to highest degree of competency for a given skill area. The first, or lowest level of competency involves a basic awareness, knowledge, or understanding of a specific area. Individuals at this level will have an elementary familiarity and knowledge about a method, technique, or process. The second level of competency describes a more comprehensive, working knowledge of procedures and/or methods. This level of competency suggests the ability to implement activities directed by another person or established by procedures. The third and most developed level of competency describes a thorough knowledge of theoretical principles, including conceptualization of all critical elements. This level of competency represents the integration of knowledge and action. It is the decision-making and program planning level. School administrators may find this approach to competency helpful in planning appropriate staff development programs for individuals with varying responsibilities.

4. *Request staff members to complete the self-assessment inventory*. This will provide them with an opportunity to focus on their strengths and weaknesses and to rank their level of performance in each competency area. (see Appendix F for sample inventory).

5. *The Inventory may be used by the teacher* (or other staff member) in conjunction with a district consultant or supervisor (e.g., school principal) to determine the individualized inservice training needs and establish staff development goals. Only those areas in which the staff does not meet the expected level of competency need be the focus of training.

6. *Determine the specific kinds of activities in which staff can engage in order to improve competency*. A range of optional activities (e.g., consultation with other professionals, formal coursework, observations of other programs) should be available to the staff. The reader is referred to the following sources for more specific information related to activities leading to increased competency: *Child Care and Development Occupations: Competency Based Training Modules; Early Childhood Special Education Training Components: Project KIDS*.

7. *The consultant or supervisor assists the staff member in the development of competency*. Such assistance can take a variety of forms, including negotiating for release time, making the teacher aware of pertinent workshops and professional training opportunities, holding regular conferences, and providing concrete feedback regarding the individual's progress toward established goals.

B. *Delivery Mechanisms for Inservice Training*

It is unlikely that any one school district will be able to meet all of the individualized training needs of its staff. Consequently, cooperative planning with other providers of inservice training in the community should be considered viable mechanisms for staff development.

1. College/Universities

These major institutions represent important sources of inservice training via the following systems:

a. *Credit courses*. Employees may gain increased knowledge and expertise via college credit courses in either degreed or non-degreed programs. Such a system usually is pursued by an individual on the basis of his perception of his professional training needs, rather than by a school district. However, it is possible for a school district or group of districts to contract with a college or university to provide credit courses on-site or at the college or university facility. Accessibility as well as credit options may be incentives for some employees.

b. *Continuing education programs*. These options offer a means of learning new skills in a less formal, less costly arrangement than college credit courses. These are generally sought by the individual rather than the employing school district. School districts may facilitate individual professional growth by publicizing relevant conti-

nuing education sessions, reimbursing for registration costs, providing release time, etc.

c. *Special workshops/seminars.* Colleges or universities may sponsor workshops or seminars designed around specialized topics for a brief period of time (e.g., week-long/weekend). These arrangements may offer credit and non-credit options. Such programs may be especially applicable to inservice training on the topic of preschool handicapped children. Sample workshops include those concerning specific evaluation procedures, IEP development, group/interpersonal dynamics, etc. School districts may incorporate such offerings into their inservice plan by giving release time or paying stipends to employees to attend, reimbursing for registration fees, or by offering salary increases for additional credit hours.

2. Professional Organizations

A variety of professional organizations offer continuing education to members. Examples of professional organizations which can provide relevant inservice concerning preschool handicapped children are:

- Association for the Education of Young Children (national, state, and local)
- Council for Exceptional Children (national, state, and local)
- Association of School Psychologists (national, state, and local)
- The Association for Severely Handicapped (national and local)
- Psychological Associations (national, state, and local)
- Occupational Therapy Associations (national, state and local)
- Physical Therapy Associations (national, state and local)
- Speech and Hearing Therapists' Associations (national, state and local)
- Association for Children with Learning Disabilities (national, state and local)
- Headstart (national and regional)
- American Association on Mental Deficiency (national)

The types of inservice generally provided by organizations of this kind are:

a. *Local, state and national conferences.* These regularly scheduled meetings generally feature workshops or seminars that respond to the needs of members for professional growth. Many of the groups listed above have recently begun to focus on preschool handicapped children. Individual conference programs will provide the best information about specific training offerings, and the potential for college credit or CEU's (continuing education units). School districts may find that involvement of staff in such conferences provides the most current and comprehensive information in the least expensive manner, and for this reason may want to include national or state conferences in their inservice plan for staff working with preschool handicapped children. Release time and/or reimbursement may be offered to staff as incentives.

b. *Publications.* Via newsletters, journals, and special communications, professional organizations keep members informed about current issues of importance, including the topic of preschool handicapped children. While not an active approach to inservice, professional journals do provide a valuable function in the ongoing professional development of staff. School districts may find it worthwhile to subscribe to a variety of relevant professional publications which may include features on preschool handicapped children.

3. Child Development Associate Consortium (CDA)

The Child Development Associate Consortium (CDA) was established in 1972 to assess the competence of child care personnel and to grant credentials to those persons assessed as competent. The consortium is a private, non-profit corporation with a representation from 42 national associations whose main concern is child development and/or early childhood education. The consortium has established a vehicle for assessing, training, and strengthening the competency of child care professionals, which results in their being awarded a CDA credential. The credential is recognized as a minimum training requirement in some states

for staffs in various child care facilities. CDA focusses on thirteen areas of competency: safety, health, learning environment, physical, cognitive, language, creative, self-concept, individual strength, social, group management, home-center, and staff.

The assessment of an individual's competencies is performed by a team composed of a trainer, a parent-community representative (consumer), a Consortium representative, and the candidate. The major focus of the assessment is the structured observation of the candidate in a variety of real-life episodes, coupled with a feedback system to the candidate. The resulting credentialing generally occurs after several hours of careful, controlled observation, feedback, self-evaluation, and implementation of suggestions.

The CDA represents a type of inservice training unfamiliar to most public school districts. Perhaps the closest analogies are student teaching, supervised internship or field experience. It does seem, however, that the CDA offers potential to school districts, especially in circumstances in which individuals who have previously worked with older school-aged children are being utilized to staff programs for preschool handicapped children. Via CDA training, an individual can obtain essential experience and feedback about the nature of very young children in a structured, supportive arrangement.

Either individuals or school districts can make application for an individual to receive CDA training. If an individual makes application, the school district must agree to cooperate by allowing the CDA trainer access to the program during the assessment phase. If a school district determines that CDA credentialing is an important inservice training experience for their staffs in preschool handicapped programs, they may decide to contract for CDA credentialling with an agency or individual CDA trainer.

4. Instructional Resource Centers

Ohio is served by 17 Special Education Regional Resource Centers charged by the Ohio Division of Special Education to provide relevant services concerning handicapped children to parents and educators. Each Special Education Regional Resource Center has one component called the Instructional Resource Center (IRC) which is specifically designed to deliver inservice training. School districts can find the IRCs to be a helpful resource in providing inservice training on a variety of topics, including the preschool handicapped child. The following types of inservice training can be provided through the IRC:

a. *Individually tailored inservice.* School districts may contract with the IRC for appropriate programs to meet the specific identified needs of their staff members. Often it may be most efficient for several school districts to collaborate on a regional or county-wide basis for such inservice training. Often these programs can be offered at no cost to participants or school districts. If outside consultants are involved, a registration fee may be charged, which can be paid individually or by school districts if such meetings are part of their inservice plan.

b. *Regional conferences/workshops.* The IRC often sponsors large regional conferences or workshops which school districts may want to incorporate in their local inservice training plans. Often these are planned and implemented cooperatively with other agencies and organizations. School districts can facilitate the involvement of their staff in these conferences by providing release time and/or reimbursement (when applicable).

c. *Specialty oriented workshops.* Occasionally workshops which impact a core group of specialists — primary teachers, or speech therapists, for example — are planned and implemented to respond to specific needs. These are often carried out on a regional or county-wide basis, and school districts may want to incorporate such training into the inservice programs of individual professionals, who have identified these topics as in their area of need.

d. *Inservice training packages.* School districts may wish to implement some training for staff in preschool handicapped programs on a local basis. To assist with such efforts, the IRC has for loan a variety of inservice packages, including handouts, media presentations, activities, etc.

5. Individual Consultants/Agencies

School districts may choose to provide inservice training through the utilization of private

consultants or through consultation with agencies. While such an arrangement may provide the best mechanism for responding to the identified training needs of staff, individual districts may find it less costly if they cooperate with other school districts to share the cost of consultants and increase the number of staff trained. Some agencies in the community offer occasional workshops for professionals at low or no cost. Public school personnel may be able to take advantage of these offerings.

6. Consultants Within the District

   Individual staff members may demonstrate special expertise and interest in an area related to early childhood/special education, and be called upon to lead workshops or give technical assistance to co-workers. Examples of this arrangement are: a psychologist who has special skills in assessing preschoolers, who shares this information with other psychologists, and an early childhood teacher conducting a workshop session on child growth and development for specialists (i.e., speech therapists, psychologists) in the district.

C. *Considerations in Delivering Effective Inservice Training Programs.*

The list of delivery mechanisms provided aboye includes several options for the purchase of inservice training by school districts. It is imperative, regardless of the method utilized, that a systematic procedure be incorporated to assure that inservice training responds to areas of need and produces the desirable effects. Characteristics of inservice training programs which have universal importance are listed below:

1. *Inservice programs should be ongoing.* Programs which reflect disjointed, single presentations, while they may serve to temporarily motivate or inspire staff, lack the carryover necessary to produce significant changes in attitudes and actions. A series of sessions on a single topic may provide the opportunity for in-depth study of an issue.
2. *The concept of the early childhood inservice program should be interwoven into the philosophy of the district* and, when possible and appropriate, be incorporated into other major activities of the district reflecting a comprehensive plan.
3. *The plan for inservice training should be actively supported by district policy makers,* and their commitment to the plan as well as the philosophy should be visible. Involvement with staff in the implementation of the plan, rather than a practice of sending others to be trained, represents one means of demonstrating such commitment. Other ways which have already been mentioned, such as administrative reimbursement for costs, providing substitutes, and giving incentives for participation in inservice, also demonstrate commitment.
4. *Prospective trainees in the system need to be involved in the program planning* in order to develop identification and commitment to the need for and process of training. Often this can occur when an elected or appointed core of individuals, representative of the total staff, participates in a planning body.
5. *Inservice training programs need to respond to the needs of staff as they perceive them.* Via formal or informal needs assessments, information about identified needs can be collected and utilized by the planning committee. Structured questionnaires, including items pertaining to a variety of issues within a single topic, for example, will allow the program to respond to staff needs while incorporating administrative direction setting as well.
6. *Inservice programs may be most effective if the target group is heterogeneous in terms of educational level, occupation, age, discipline, sex,* etc. Such a plan reflects a philosophy which underlies the implementation of the components of P.L. 94-142. In addition, it may help implementers avoid pitfalls associated with the assumption that educational level and competency are synonymous. Persons from various disciplines can benefit from the interaction and achieve a greater understanding of and respect for one another. While there will certainly be occasions when the total staff will need to be divided into subgroups, these divisions can occur on the basis of need and not on preconceived ideas about competency.
7. *Inservice training programs need to have clearly stated objectives* so that participants are clear from the onset about the intent and purpose for the program. It is suggested that these be presented in several ways — orally and in writing, for example — and that some thought be given to an individual commitment to the objectives via a "professional growth plan" or "inservice contract."

8. *Additional structure needs to be provided to participants* via clearly specified timelines, schedules, etc. It will be easier to maintain involvement if participants are aware of what will occur, when, under what conditions, and what their individual contributions are to be.

9. *Inservice training programs need to be coordinated with other procedures which may also impact the participants.* Occasionally inservice training programs fail because they must compete with other issues for participants' time and attention. Individual training programs (e.g., post baccaleaureate degree programs), contractual negotiations, or adoption of new curricula are examples of factors which may doom an otherwise effective inservice training program.

10. *Inservice training programs are perhaps most successful when implemented via an action-oriented approach.* Staff members need opportunities to experiment with concepts and methods presented and to see for themselves the relevance. This issue also speaks to the motivation of participants to change, to adapt, and to incorporate, and a system to encourage motivation should be an integral part of the training program.

11. *Participants need to comprehend the benefit of the program's objectives,* especially as it impacts them as individuals. Program planners need to assume the "what can it do for me?" attitude is a given, and be prepared to address this directly in initial stages of the program implementation. A variety of extrinsic motivators can be adopted, in addition to those more intrinsic rewards which speak to the improvement of service to clients or similar results. Examples of benefits to participants include stipends, continuing education units, college credit, additional certification, release time, and increased support staff.

12. *The program needs to include a system of ongoing feedback to participants* in a fashion which is unrelated to staff appraisal. Non-threatening feedback for the purpose of improving effectiveness will help stimulate staff commitment and change.

13. *A district needs to adopt a variety of approaches to inservice* to accommodate the disparate needs of staff and maintain flexibility in allowing individuals to select those mechanisms that most closely meet their needs.

14. *Other activities traditionally not perceived as in-service must be considered as valuable staff development efforts.* Examples include visitations to other related programs within the district or outside, access to material resources which will enhance the skills and knowledge of staff, recognition of superior work by staff which reinforces their behavior and encourages professionalism, and opportunities for information sharing with peers.

15. *The program itself needs to include a component for evaluation by participants* in order to determine its effectiveness in meeting objectives. Such evaluation needs to be ongoing throughout the year and to assume a variety of different reporting systems. Administrators, advisory groups, parents and the participating staff might give input to the evaluation of training outcomes.

D. *Inservice Topics*

While the specific inservice topics selected will depend on the training needs of individual staff members, it is likely that those areas encompassed in the "Self Assessment of Basic Competencies" (Appendix F) will form the core content of the training.

PARENT PARTICIPATION/EDUCATION

"It is generally accepted that, if a person does not view himself as an adequate and worthwhile human being, he cannot function adequately in his parenting role. Parents, then, are first people, and secondly parents and programs for parents must give prime consideration to the needs of the individuals involved."

Project KIDS, Dallas

Rationale and Philosophy

The primary difference between delivery of services to preschool handicapped children and to school-aged populations is that in the former there are two essential recipients of service: the handicapped child and the parent(s). With school-aged populations, the child has traditionally been the sole focus for service. However, because of the nature of infants and young children, the parent must be an integral component in the system when serving this age group.

When school districts operate preschool special education programs, parent participation and education often occur as a logical extension of these programs. Current research shows that effective parent participation is, in fact, a main ingredient in the long term effectiveness of early childhood intervention. The systematic involvement of parents in preschool special education programs has been demonstrated to greatly accelerate the child's rate of development (Fredericks, et al., 1974). In summarizing an extensive survey of the research literature Brofenbrenner (1974) made the following statement:

The involvement of the child's family as an active participant is critical to the success of any intervention program. Without such family involvement, any effect of intervention . . . appears to erode fairly rapidly once the program ends. In contrast, the involvement of the parents as partners in the enterprise provides an ongoing system which can reinforce the effects of the program while it is in operation, and help to sustain them after the program ends (p. 55).

There are many reasons to involve parents in their children's educational process. Because the needs of young handicapped children are not always easy to assess, most professionals would agree that parents can contribute significantly to the development of functional objectives for the child. In addition, effective parent-school communication assists in the coordination of teaching and learning in the home and school settings. As consumers, parents provide direct or indirect financial support for the programs and services their children receive. If well-informed and knowledgeable about the program, parents can serve as viable advocates for the program's continuation or extension. Finally, as parents interact with professionals, as well as other parents, emotional support for feelings of isolation, loneliness and frustration, common to parents of handicapped children, is derived. The potential benefits of parent involvement include an increase in parenting skills, a greater understanding of the handicapped child, and the development of a support system. Not only do the handicapped child and the parents benefit from this parent-school relationship, but positive effects on the child's siblings and other family members have been demonstrated (Karnes & Lee, 1978; Gilmer, Miller & Gray, 1970; Gray & Klaus, 1970).

While involving parents of young children with special needs in the educational program has many benefits, it is a complex process. As described in Project KIDS, parents of handicapped children are "people with children," who have the same basic need for security, love, competence, respect, and acceptance as other individuals. At the same time, they may have pressing personal problems (e.g., financial, marital, employment, siblings, single parent) which interfere with their concentration on the needs of the special child and are thus barriers to their participation. Programs for parents must give prime consideration to these needs, since they directly impact the individuals' capacity for fulfilling the parenting role.

In working with parents of preschool handicapped children, professionals need to be aware of and sensitive to parents' adjustment to their children's handicaps. In this process of adjustment parents may move through a number of stages (e.g., denial, anger, guilt, depression, bargaining, and acceptance) somewhat characteristic of the mourning or grieving process (Seligman, 1979). As part of their helping role, professionals must recognize that the process cannot be hastened, even though some of the parents' affective behaviors might appear to interfere with their children's progress and the communication between school and the home.

Another area to which professionals must be especially sensitive is that of parents' fears about parenting the handicapped child. Parents may feel unable to cope with the special needs of a handicapped child and unprepared to serve as a primary educator for the child. Such obstacles can be addressed in parent education programs which will allow parents to gain experience and develop confidence in their teaching capacities.

In order to be responsive to parent needs and to maximize the benefits of service to young handicapped children, school districts must initiate and sustain parent support and involvement. In the majority of public school districts which do not operate preschool special education programs, vehicles for insuring this support and involvement are less apparent. Because school personnel often serve in a diagnostic role, due to the identification and evaluation mandates, they may be the initial link in the chain of potential support for parents. In such instances, a sensitive referral func-

tion can spare parents from considerable fruitless searches for help. A case follower, as described in the evaluation section of this manual, may be the primary facilitator of a strong parent-school linkage. If parents of preschool handicapped children perceive these early associations as positive, such interactions establish a favorable condition for subsequent involvement with the public school. Such perceptions are translated into positive school-community relationships around the child, when he reaches school age, as well as to a more general support of the school district. The benefits to the school district, the child, and the family as a result of such involvement are significant, and justify the attention given to such activities by school personnel.

If efforts to involve parents are to be successful, assessment of parent needs must be a continuing process. The needs of parents often change as their children mature or the nature of the parent group changes, and ongoing assessment of these needs permits appropriate responses. Strategies for evaluating parents' needs and developing effective mechanisms for meeting these needs are described below.

Strategies for Parent Participation/Education

To assure appropriate response to parent needs for participation, education, and support, school district personnel must first have a clear understanding of those needs. Such needs might be assessed through a one-to-one informal interaction of parent and professional or through the formal administration of a questionnaire (see sample, Appendix G). Any participation by parents in this assessment process should be on a voluntary basis. In numerous cases, parents have indicated a need for:

A. *Information*
- — written and verbal information on available community and school resources for diagnostic, therapeutic, social, medical, dental, legal, recreational and financial services.
- — concise explanation of P.L. 94-142, clarification of guaranteed parents' and child's rights and implications for services tc preschoolers.

B. *Education*
- — normal child growth and development
- — characteristics of exceptionalities
- — child management techniques
- — appropriate intervention/teaching strategies
- — appropriate materials and toys
- — expectations of systematic processes and procedures for evaluation and placement
- — involvement of family members with the education of the exceptional child
- — effective parent/community communication techniques

C. *Counseling*

D. *Advocacy*
- — in the development of parent support groups
- — in helping parents find existing support groups.

A number of mechanisms either within or outside of the school district can be utilized by personnel in their efforts to respond to the needs of parents. School personnel are likely to take very active roles in the initiation and coordination of in-district parent groups. For parent groups outside of the district, school district personnel may be less likely to take a coordinating role, instead providing support to parent efforts to participate in other groups and organizations.

I. Parent Involvement Within the School District

A. *Parent Group Affiliated with Program*

Frequently, specialized programs that provide services to preschool handicapped children include organized parent groups which give feedback to and support the function of the educational program, assist in the financial support of the program (e.g., fund raising activities), provide a supportive system for members and/or maintain a level of parent involvement which recognizes the parent as primary in the life of the child. This group is likely to be tied closely to the school, with staff involved in guiding the direction of the group, giving consistent input or supporting the efforts of the parents. It may be parent initiated or school initiated; however, once begun, it continues year after year with parents joining and other parents being involved in varying degrees and capacities, depending on their specific needs.

1. Purpose
   a. To emotionally support parents
   b. To share information
   c. To improve parent-child relationships
   d. To promote parent participation
2. Participants
   a. Parents

b. Supervisor or School Psychologist
c. Teacher and aide
d. Support personnel

3. Procedure
   a. Conduct needs assessment to determine parent needs
   b. Use results of assessment to form objectives
   c. Establish activities based on objectives
   d. Determine evaluation procedures
   e. Select topics and engage speakers for meetings
   f. Publicize meetings with parents and others
   g. Provide for refreshments, name tags, room arrangements, etc.
   h. Make personal contact with parents for first meeting
   i. Arrange car pools, baby sittings, etc., if desired
4. Advantages
   a. Provides forum for parent-to-parent and parent-to-staff communication
   b. Builds skills for better parent-child interaction
5. Disadvantages
   a. Staff time involved in coordination
   b. The school atmosphere may be threatening to some parents
6. Other considerations
   a. Will parents from previous years' programs be invited to join with the new parents to support them and be advocates for the program?
   b. Will parents cooperate with school district personnel and design and execute the needs assessment?
   c. Are the objectives and expectations suitable?
   d. Will the group be formal or informal?
   e. Which staff member(s) will be responsible for organizing this parent group?
   f. Will ongoing coordination be provided by professional staff member or a parent member of the group?

B. *Parents Supporting Parents in the Home*

For those parents of handicapped preschool children who are unable to take part in a program affiliated parent group, this mechanism provides support to parents in their homes. Parent volunteers are trained as home visitors and go into the home to share information on child development, handicapping conditions, etc. and to help parents adjust to family life with a handicapped child. The school district's primary role is to facilitate the organization of such a system, lend staff for coordination and monitoring efforts, and encourage parent participation.

1. Purpose
   a. To provide emotional support
   b. To share information
   c. To promote parent-school communication
   d. To improve parent-child interaction
2. Participants
   a. Former parents of the program
   b. Current parents of the program
   c. Parents of other special education programs
3. Procedure
   a. Assign or hire staff member to coordinate program
   b. Conduct needs assessment
   c. Use results of assessment to identify goals and objectives
   d. Conduct public relations campaigns
   e. Recruit, screen and select parents to serve as home visitors
   f. Determine training needs of home visitors
   g. Conduct training
   h. Match home visitor to parent and set visitation schedule
   i. Schedule periodic meetings with home visitors
   j. Evaluate program
4. Advantages
   a. Need for limited professional staff
   b. Serves a previously unserved parent population
   c. Cost effective
5. Disadvantages
   a. Recruiting and training of volunteers
   b. Turnover rate of volunteers

6. Other considerations
   a. What is the size of the district? A large urban district may use this system as an extension of existing programs and services, while a smaller rural area may use it as a starting point for serving families of young handicapped preschoolers.
   b. How will confidentiality with parent volunteers be handled?

C. *Parent Teacher Association*

Traditionally, parents of handicapped children have not taken an active role in PTA, an organization of parents and teachers which supports the functions of the school and establishes a two-way communication link. Currently, local district, and statewide PTA councils are establishing Special Education of Handicapped Children Committees for the purpose of sharing information with parents about the continuum of special education services within the educational system. In addition, PTA groups are establishing Pre-School Committees. It seems especially appropriate, at this time, for parents of handicapped preschool children to be included in this information-sharing process. School personnel can play a vital role in encouraging the participation of all parents in the PTA.

1. Purpose
   a. To promote parent-school communication
   b. To address concerns of parents
   c. To share special education concerns with teachers and parents of non-handicapped children
   d. To support the goals and objectives of the school
2. Participants
   a. Parents
   b. Teachers
   c. Other school personnel
3. Procedure
   a. Select Special Education Committee Chairperson at building and council levels
   b. Select Preschool Committee and Chairperson at building and council levels
   c. Conduct needs assessment of both special education and preschool parents in district
   d. Share results of needs assessment with PTA
   e. Form sub-committees to address needs as appropriate
   f. Special Education and Preschool Chairpersons may link with other PTA representatives throughout the district
4. Advantages
   a. Established PTA exists within most school districts
   b. Mechanisms for the establishment of Special Education Chairpersons at the local level is already in existence at the Ohio State PTA level
5. Disadvantages
   a. Parents of handicapped children may feel PTA is not the appropriate vehicle for meeting the needs of Special Education parents.
   b. PTA is legitimately concerned with a number of issues other than special education
6. Other Considerations
   a. How effective is the PTA within the system? Are a number of parents involved?
   b. Are there several parents of handicapped children who would be interested in participating in PTA?
   c. What special plans for recruitment of this population of parents have been made?

D. *Parent Education System*

If no formal groups or organizations exist to meet parents' needs, consideration might be given to establishing a parent education system. This system might involve information sharing via written or verbal communication, or may be included as one component in a more comprehensive adult continuing education program. Parent education sessions should be designed to meet the specific needs of the parents in the district; however, such efforts should be incorporated with other school district and community efforts to avoid duplication of already effective parent education services.

1. Purposes
   a. To share information
   b. To build parenting skills
   c. To support parents
   d. To involve family members in the exceptional child's education

2. Participants
   a. Parent education coordinator
   b. Personnel from other service providers
   c. Parents
3. Procedure
   a. Designate parent education coordinator
   b. Assess other parent education services in the school district and in the community
   c. Conduct needs assessment of parents
   d. Consider linkage with community service providers or other school districts for a cooperative and comprehensive parent education effort
   e. Prepare appropriate parent education materials and formats
   f. Conduct evaluation of parent education efforts
4. Advantages
   a. Provides an on-going mechanism for communicating with parents
   b. Allows parents to meet other parents
5. Disadvantages
   a. May not meet specific needs of preschool parents if open to all parents in the district
   b. May lack continuity in addressing issues of concern
6. Other considerations
   a. Will specific parent education sessions be limited to parents of preschoolers? Are the needs of these parents different from the needs of parents of older children?
   b. Will parents be involved in the planning of the parent education program?
   c. Will the parent education topics be repeated on a yearly basis or will new topics be added?

E. *Other types of Parent Involvement*

Parents can be involved in many phases of an early childhood program. The following is a list of some additional roles parents may fulfill.

1. *Staff Member* — parents may serve as volunteers in the classroom, a function which can be of value to both the program and the parent. Some programs use parents as paid aides in the classroom.
2. *Referral Source* — parents may also serve as a source of referrals and may take responsibility for public relations and dissemination of program information within the community.
3. *Observers of their Children* — one of the best ways to involve parents in the preschool is by having them observe their children in the classroom. Not only is this a vehicle for helping the parent understand what goes on at school, but it represents a form of parent training.
4. *Decision Maker* — in many programs (e.g., Headstart, Parent Cooperative Preschools) parents play key roles in decision-making about program development. In these and other settings, they work cooperatively with staff to determine the goals for the development of their children.

More comprehensive descriptions of parent involvement alternatives are included in a wide range of materials referenced in Appendix H.

II. Parent Involvement Outside the School District

The primary role for school district personnel in involving parents of preschool handicapped children who are not enrolled in a public school program is one of information sharing and encouraging parents' efforts in seeking services for their children. Throughout the identification and evaluation process, the case follower (described elsewhere in the manual) carries out various functions related to these activities. It is recommended that information on the following resources be collected and disseminated to parents as requested.

A. *Available Programs Within the Community*

Such programs might include specialized nursery school programs which are operated by private agencies or organizations, or regular community nursery schools which have mainstreamed special needs children. A community based information and referral office or the local SERRC may maintain a listing of various programs, and these may be excellent resources to district personnel.

B. *Community Resources for Parents, Children, and/or Family*

Such resources might include specific parent oriented projects, mental health centers, information about financial assistance (e.g., social security, Bureau for Crippled Children's Services) and medical services.

C. *Parent Support Groups*

Such groups, often associated with specific

organizations or concerned with individual handicapping conditions, can assist parents by providing information, education, and support functions. School personnel can apprise parents of the various parent group options and support them in their efforts to utilize such groups.

Prior to referring parents to resources outside the school district, the case follower and other personnel, as appropriate, should be knowledgeable about these resources (e.g., purpose of service, service limitations, contact persons, appropriateness for defined population). Providing parents with accurate information and offering emotional support sets the atmosphere for long-term positive parent-school communication. For these reasons, school district personnel who have contact with parents of preschool handicapped children are encouraged to provide the maximum levels of information and support possible, and to facilitate parents' linkages to direct support systems in the community.

PARADIGM

The paradigm in figure 6 depicts the various services which may be available to the suspected handicapped child and his family: identification, evaluation, placement, parent support, and staff training. These services, provided by a number of resource agents, such as public schools, community agencies and medical practitioners, are clearly not discrete, as they typically merge and overlap. Exactly when identification ends and evaluation begins is not always clear. While some agents assume a primary role in providing specific services, others assume a secondary role, or serve as facilitators or information sharers. In some cases, these roles are defined by legislative mandate (e.g., school districts are mandated by P.L. 94-142 to identify and evaluate suspected handicapped children from birth). In addition the roles may vary according to the source of initial contact and subsequent follow-up with the parent.

The following case study may serve as an illustration of the various roles assumed by public schools, agencies, medical practitioners, and other service providers:

> The Special Education Regional Resource Center received a call from the mother of a visually impaired 4 year old, inquiring about programs for handicapped preschoolers. SERRC staff informed the mother of federal and state laws concerning handicapped preschoolers, shared information about community resources, and subsequently referred the parent to the Child Find Coordinator in her school district of residence. Following the mother's contact with the school district, medical data were requested from the pediatrician who had been seeing the child from birth. It was determined by the case follower (in this case, the school psychologist) that more information was needed about the child's development; thus, a multidisciplinary team performed a multi-factored assessment. The results of the evaluation indicated that the child had need for and would benefit from an early intervention program. Contact was made by the case follower in the home district with a neighboring school district which offered the kind of program needed by the child. Because space in the program was available and the parent and personnel from both districts agreed that the program was appropriate, the child was subsequently enrolled. The school district of residence has a policy to pay tuition and transportation costs for visually impaired preschool children, and a representative of the district participates in the annual review of the child's program. The parent is involved in a group for parents of handicapped children which is sponsored by the school district the child attends.

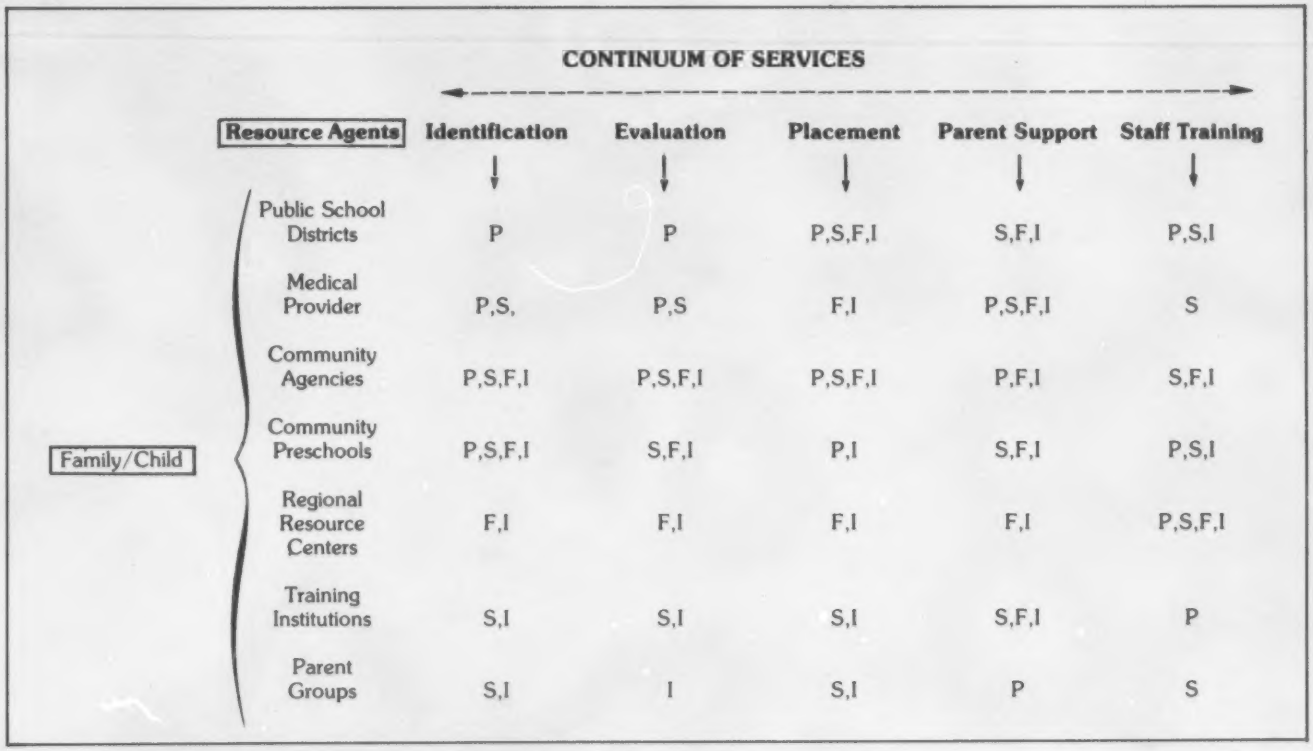
In this example,

SERRC assumes the information-sharing role (I) during the identification process. This information directed the parent to the appropriate professional in her district.

The *Pediatrician* role is primary (P) in the identification process because this professional was the initial point of contact for the parent at the child's birth. Although the pediatrician had accumulated much medical information on the child, this role was secondary (S) in terms of educational evaluation.

School District of Residence role was primary (P) during the phases of evaluation and placement. It can be said that the district's role also included facilitation (F) and information sharing (I) during placement as various options were explored with the parent.

School District of Placement assumed a primary (P) role for placement, as well as for provision of parent support via the parent group.



P — primary role
S — secondary role
F — facilitating role
I — information sharing role

Figure 6. A Model for Comprehensive Service Delivery for Preschool Handicapped Children

APPENDICES

Appendix A
Model Development

PARTICIPANTS IN MODEL DEVELOPMENT

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Jan McFarland . . . . . Cuyahoga Heights School District
Larry Tout . . . . . Kent State University

Medical Advisory Board

Elizabeth Campbell . . . . . Maternity and Infant Care Project, Metropolitan General Hospital
Dr. William Clem . . . . . Private Pediatrician
Maxwell Davis . . . . . Group Health Plan of N. Ohio
Dr. Jana Fisherova . . . . Thomas McCafferty Health Center
Debra Gordon . . . . . Developmental Specialist, Cleveland Regional Perinatal Network
Mary Hallstein . . . . . Cuyahoga County Board of Health
Dr. Karl Hess . . . . . Kaiser Medical Center
Patricia Hull . . . . . Comprehensive Care Unit, Metropolitan General Hospital
Gertrude Jerome . . . . . Visiting Nurses Association
Dr. Ted Kurczynski . . . . . Pediatric Neurology, Rainbow Babies and Children's Hospital
Mary Ann McMurray . . . Cuyahoga County Board of Health
Ms. Francis Majetic . . . . Thomas McCafferty Health Center
Dr. Burni Samal . . . . Kenneth Clement Health Care Center
Paul Stephan . . . . . Developmental Specialist, Cleveland Regional Perinatal Network
Raminta Vaitenas . . . . . Cleveland Perinatal Network
Dr. Creed Ward . . . . . Private Pediatrician

Parma School District Staff

Sherrie Kuehner . . . . . Director, Special Education
Carol Lassak . . . . . Vocational Education Coordinator
Donna Muthersbaugh . . . . Speech and Language Therapist
Jean Paulus . . . . . Special Education Teacher
Kathy Quintus . . . . . School Psychologist
Sharon Simmer . . . . . Special Education Teacher
Virginia Steininger . . . . . Vocational Child Care/ Early Childhood Teacher

Parents, Parma School District

Doris Day
Flo Izzo
Alice Lisy
Diane Lupo

Shaker Heights School District Staff

Cathy Cleary . . . . . Early Childhood/ Special Education Teacher
Beverly Hopcraft . . . . . Early Childhood/ Special Education Teacher
Dale Jakob . . . . . School Psychologist
Sam Sexton . . . . . Director, Special Education
Pat Shay . . . . . Assistant Teacher

Cleveland School District Staff

Dena Arbitman . . . . . Liaison Teacher
Christine Branch . . . . . Director, Early Childhood Education
Benjamin Candee . . . . . Director, Psychological Services
Linda Edwards . . . Coordinator, Pupil Adjustment Program
Jean Ehlert . . . . . Assistant Supervisor, Visually Impaired Programs
Donna Eichmuller . . . . . Coordinator, Multihandicapped Programs
Bernice Eisenberg . . . . . Coordinator, Parent Involvement
Keith Gainey . . . . . Director, Special Education
Eleanor Hodgekiss . . . . . Director, Cleveland Christian Home Day Care
Joan Holden . . . . . Special Education Teacher
Lenore Ivy . . . . . Coordinator, Field Services
Murdine Morris . . . . . Coordinator, Health Services
Josephine Perry . . . . . Coordinator, Curriculum Services
Eleanor Talarico . . . . . Special Education Teacher
MaDonna Welsh . . . . . Principal, A. G. Bell and Sunbeam

School/Community Task Force

Betty Barnett . . . . . County Board of Mental Retardation
Erica Boehnke . . . . Cuyahoga County Welfare Department
Ann Bowdish . . . . . Positive Education Program
Sandra Collins . . . . . Neighborhood Centers Association
Debbie Croucher . . . . Bureau of Crippled Children Services
Gayle Haber . . . . . Cleveland Society for the Blind
Connie Henderson . . . . . Cuyahoga Easter Seal Society
Patricia Hull . . . . . Comprehensive Care Unit Cleveland Metropolitan General Hospital
Ruth Kruger . . . . . Parkview Therapeutic Nursery School
Bernadette LaGuardia . . . . Maternity & Infant Care Project Cleveland Metropolitan General Hospital
Lelia Leake . . . . . Council for Economic Opportunity, Headstart
Penny Lengyl . . . . . Society for Crippled Children

Dan Luther . . . . . Bureau of Crippled Children's Services
Patricia MacIntyre . . Cleveland Speech and Hearing Center
Mary Pfordresher . . . . . Cuyahoga County Board of Mental Health and Mental Retardation
Meredith Reusser . . . . . West Shore Preschool
Joyce Roitblat . . . . . Early Periodic Screening, Diagnosis & Treatment
Suzanne Schuler . . . . . Broadway Health Center
Mimi Sobel . . . . . Beachwood Public Schools
Laurel Shauer . . . . . Mental Development Center
Eileen Timko . . . . . Cleveland City Health Department
Nancy Washburn . . . . . Community Information Services
Judy Watson . . . . . United Cerebral Palsy Association

Criteria for Selection of Pilot Subregions for Field-testing

1. The three pilot subregions will be defined by the boundaries of a single school district or a designated portion of a single school district. Since the responsibility for identification of handicapped children rests with the school district of residence, it is logical to use school district boundaries as natural definitions to subregions. As the model is field-tested and assessment and placement alternatives are considered, resources outside the boundaries of the designated subregions may be involved.
2. The three selected regions will be representative of the eastern, western, and central portions of Cuyahoga County. To the degree possible, the selected subregions will be culturally and economically diverse.
3. The school district or portion of school district within the designated subregion must currently operate one or more preschool programs serving handicapped children. Initially, priority may be given to districts with a greater number of programs.
4. The school district or portion of a school district within the selected subregions will sign an agreement to participate, which will include the assignment of an individual to serve as liaison to the SCCS Preschool Project, agreement to cooperate with the Project Coordinators in field-testing and evaluation, and agreement to participate with staff and the consultant team in the development and revision of the various stages of the model.
5. The subregions selected will contain preschool and/or daycare programs not affiliated with the public schools.

Outline of Pilot School Districts' Participation in Field-testing

Description of Preschool Project

The Preschool Project is a research and demonstration project which focuses on delivery of service to very young handicapped children. Through input from a consultant team, professional staff in the areas where field-testing occurs, and parents, procedures pertaining to identification, evaluation, school-community coordination, staff and parent training will be written and field-tested. At the end of the project duration (in August, 1981) a written manual of procedures will be available for replication in other areas in the state.

School District Participation

Participation by a school district is on a voluntary basis. It is an opportunity for a district to participate in a research project which has significant future implications for families, agencies and other districts in Cuyahoga County. Ideally, participation would involve the following staff in these ways.

1. *Psychological staff, speech therapists*, etc. would participate primarily in identification and evaluation phases of the model. It is important for Preschool Project staff to be aware of current practices of the district as they relate to identification and evalution. Also, to the degree possible, model practices and procedures could be field-tested by these staff members to provide Preschool Project with information about their effectiveness.
2. *Preschool teachers, Headstart staff*, etc. may participate in identification and evaluation, as well as school-community coordination. Procedures for inter-disciplinary planning and data sharing are important areas for which staff may want to concern themselves.
3. *Administrative personnel* may be most involved in the area of Child Find (identification), district policies pertaining to service to preschool children, and due process procedures. Again, current district practices are of major concern, in addition to feedback about any new procedures adopted as a result of field-testing.
4. *School Nurses, social workers*, etc. are often involved in identification and placement of very young children. Their knowledge about existing practices and their willingness to implement new procedures for maximizing service to young children and their families are ways in which they could participate in the field-testing.

Involvement in the Preschool Project field-testing by pilot school district staff can range from minimal to extensive, at the discretion of the individual districts. By devoting some degree of staff time to trying new procedures and reflecting on their effectiveness with Preschool Project Staff, it is anticipated that the greatest benefits to the district will result. Pilot school districts will emerge at the end of the project with written guidelines pertaining to the identification, evaluation, and school-community interactions which ultimately lead to effective programming. Such guidelines will aid school districts in complying with state and federal mandates.

At minimum, Preschool Project staff request a monthly meeting (during the period of Feb. 1 - May 30, 1980) with one or more staff from the pilot district. The purpose of this meeting (1-2 hours in length) will be to determine what portions of the model have been implemented and how effective they have been. This input will be utilized in revision of the model. A meeting with a team of personnel (e.g., psychologist, speech and hearing therapist, preschool teacher, nurse) would perhaps provide the greatest insight, but this may not always be possible or desirable.

Appendix B
Preparation for Model Implementation

SELF-ASSESSMENT OF SERVICES TO SUSPECTED HANDICAPPED PRESCHOOLERS

School District _____ Date _____

Person Completing Form _____ Position _____

Procedures	Yes	No	Office/Personnel Responsible	Briefly Describe
Written policies re: service to children under 5 suspected as handicapped				
"Child Find" activities outlined a. Community linkages				
Written procedures for screening a. Community linkages				
Screening instruments available				
Written procedures for evaluation				
Evaluation instruments available a. normative evaluation tools b. criterion-referenced tools c. tools to assess all areas of development				
Informal assessment strategies utilized				
Professional staff skilled in administration of evaluation instruments				
Multi-disciplinary team available for evaluation				
Out-of-district Resources for evaluation available				
Written eligibility criteria for educational program				
Written description of placement process a. official placement b. alternatives to official placement				

Procedures	Yes	No	Office/Personnel Responsible	Briefly Describe
Staff Involvement a. case follower b. public health nurse c. early childhood specialist/ teacher d. special education specialist/ teacher e. support staff				
Procedures for assessing staff competencies				
Procedures for assessing staff training needs				
Written systematic plan for inservice				
Procedures for evaluation of inservice efforts				
Plan for assessing parents' needs				
Parent participation a. in identification process b. in evaluation process c. in placement process d. in program development e. in parent education groups f. in parent support groups				

SCCS Preschool Project
Cuyahoga Special Education Service Center
14605 Granger Road
Maple Heights, Ohio 44137

DEFINITION OF TERMS*

Agency –

An organization, institution or group of persons established to provide a variety of services to a defined population. In the context of this model, agency refers to medical clinics, mental health centers, social service organizations, community based preschool programs, etc. that provide services to the handicapped preschool child.

Assessment –

The use of a variety of formal and informal procedures to focus on an individual's specific skill areas, to establish short and long term objectives for the individual's educational plan based on determined need and to monitor developmental progress on an ongoing basis.

Child Development Team –

A group of specialists from different disciplines (branches of knowledge), all of whom have some interest in specific aspects of a child's growth and development. More than one type of Child Development Team exists:

a. *Multidisciplinary* – Evolved from the medical model where various persons with expertise in diverse areas bring their particular knowledge to bear in dealing with a particular child. The primary way it is used in special education is in the initial evaluation of the exceptional child. One member of the team may collect the data and recommendations from team members. No team decisions are made, but individual specialists implement their own plan for the child.

b. *Interdisciplinary* – In the design of this model, the child is seen by various members of the team and evaluated by these team members. A group decision is made regarding recommendations for the child. Thus, each team member offers input to the total programming for the child by group concensus.

c. *Transdisciplinary* – The evaluation process is the same as the multidisciplinary and interdisciplinary approaches. However, implementation is carried out by only one of the team members in cooperation with others. One person represents more than one discipline and is able to deliver services based on multiple disciplines.

Developmental Delay –

The status of a child's growth process in which he performs like a normal child of a younger chronological age in one or more areas (physical, cognitive, social, emotional). He is proceeding through the appropriate sequence of stages but at a much slower rate than expected in the area or areas of delay.

Diagnosis –

The use of a variety of professionally developed and administered tools or instruments to determine if an individual who has a high probability of manifesting a handicap 1) does, in fact, have a problem; 2) what the nature and extent of the problem is; 3) what the prognosis is and; 4) what, if any, is the appropriate program for the individual.

Education –

Provision of services which will remediate the cause of handicapping conditions and will promote the optimal development of the individual learner. "Education" may include such non-academic areas as life-skills, motor functioning, etc.

Handicap –

Used to refer to nine conditions recognized by the Ohio Division of Special Education: deaf or hard of hearing, speech handicapped, visually impaired, orthopedically handicapped, developmentally handicapped, specific learning disability, severe behavior handicapped, multihandicapped, or other health impaired.

In-depth Evaluation

Terms used interchangeably with "diagnosis" to refer to an individually designed process performed by professionals from a variety of disciplines to determine whether or not an individual has a handicap, is in need of special education services, and what the current levels of functioning are.

Intervention –

Refers to any planned change in the child's life-educational, medical, etc. – designed to remediate one or more specific areas.

Model –

A focussed description of methods, strategies, approaches, techniques, procedures, or practices which are appropriate for implementation by organizations, groups, institutions, or systems. The term is used in this document to describe flexible alternatives based on non-hypothetical constructs.

Preschool Child –

Used to describe any child ages birth to 5, whether or not enrolled in any type of intervention program.

Screening –

Brief assessment procedure designed to separate those individuals who have a high probability of manifesting a handicap from those who do not.

Special Needs –

Terms used to describe the unique educational needs of a preschool child whose physical, cognitive or emotional development is deviant from or considerably slower than the "average" child of the same chronological age.

*For additional definitions of special education terms refer to Davis, 1980; Kelly and Vergason, 1978.

SUMMARY

FEDERAL AND STATE MANDATES FOR PRESCHOOL HANDICAPPED CHILDREN

Identification and Evaluation

P.L. 94-142

". . . all children who are handicapped, regardless of the severity of their handicap, and who are in need of special education and related services are identified, located and evaluated."

Ohio Revised Code

". . . assure compliance with a state plan for the identification, location and evaluation of **all** handicapped children in the state . . ."

Service

P.L. 94-142

". . . a free appropriate public education is available for all handicapped children aged three through eighteen within the state no later than September 1, 1978, and for all handicapped children aged three through twenty-one within the state not later than September 1, 1980, except where inconsistent with state law or practice."

Ohio Revised Code

". . . for the placement and provision of special education and related services for all handicapped children of compulsory school age and for the **availability** of educational placement and special education for handicapped children not of compulsory school age."

". . . grant permission to establish and maintain identification and diagnostic services for persons below the age of three and may offer parental counseling services to their parents."

Section 504 of the Rehabilitation Act of 1973

"No otherwise qualified handicapped individual in the United States . . . shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits or be subjected discrimination under any program or activity receiving financial assistance."

PHILOSOPHY(S)

Serving the Young Handicapped Child (0-4)
We Believe That:

Next to the parent(s), the personnel of this public school district have, collectively, the most comprehensive concern for, and responsibility to facilitate the intellectual, physical, social and emotional growth of the children residing within the boundaries of this school district.

Insuring the maximum potential growth of children who are handicapped requires effective collaboration among parent(s), the personnel of this school district and selected practitioners and persons from a wide variety of public and private agencies in the surrounding community.

For most children with handicaps, providing appropriate intervention at the earliest possible time after discovery of a possible handicapping condition will maximize the probable effect of the intervention. This will serve to reduce or remove obstacles to a child's normal progress toward a full and independent life in accordance with his/her potential as well as acceptance by society as a free and worthy human being.

Families (parents) of a young child with a suspected or known handicap need extraordinary encouragement and individualized opportunities to become master architects in partnership with qualified school and agency personnel in planning appropriate special educational and related interventions for the child.

Therefore, we affirm that:

Personnel in this school district will do everything within their power to facilitate the identification and location of every suspected handicapped child living in this school district as early as possible and appropriate.

Parents (families) of (suspected) handicapped children will be accepted as, and encouraged/enabled to be partners in the processes of identifying, locating, evaluating and placing and/or arranging for needed specialized services for any young handicapped child (0-4) living in this school district.

Personnel in this school district will seek continuously to improve communications between themselves and appropriate practitioners and personnel in community agencies whose services and resources can contribute to and/or are part of the collaborative efforts required to maximize the potential growth and development of a young handicapped child (0-4) living in this district.

POLICY STATEMENTS

Policy Statement 1

"It shall be the policy of this school district to pursue every known opportunity to apply for state and federal funding for the support of pre-school special education and related services in response to identified handicapped children residing in this district, and upon receipt of appropriate financial support to implement such programs and services within this district and/or in collaboration with one or more separate school districts or educational agencies."

Policy Statement 2

"It shall be the policy of this school district to provide an opportunity for appropriate placement and related services to every young handicapped child (3-4) residing in this district who meets the eligibility requirements in Ohio State Special Education Standards for "low-incidence" handicapping areas (deaf, blind, crippled, multiple handicapped)."

Policy Statement 3

"It shall be the policy of this school district to assist parents of young handicapped children (0-4) to find appropriate community programs and/or services, including financial support, where necessary, prior to their enrollment at age 5 in a regular or special education program provided through this school district."

Appendix C
Resources for Identification

Child Find Materials Appropriate for Preschool Children

1. *From Crib to Kindergarten* developmental wheel: wheel rotates to show developmental milestones from birth to 5 years.

   Source: Michigan Project Find
   800-572-6955

2. *Early Warning Signs* of children with special needs: pamphlet describing major indicators by handicapping condition.

   Source: Consortium of State Departments of Education
   in the Appalachian Region
   P.O. Box 1925
   Charleston, W. Virginia 25325

3. *Watch Me Grow* developmental and measuring chart.

   Source: American Occupational Therapy Foundation, Inc.
   6000 Executive Boulevard
   Rockville, Maryland 20852
   301-770-2200

DIRECTORY OF SERRCs

SERRC	Counties Served	Address	Phone
Central Ohio	Delaware, Fairfield, Franklin, Licking, Madison, Pickaway, Union	470 East Glenmont Avenue Columbus, OH 43214	(614 262-4545
Cuyahoga	Cuyahoga	14605 Granger Road Maple Heights, OH 44137	(216) 587-5960
East Central	Belmont, Carroll, Coshocton, Guernsey, Harrison, Holmes, Jefferson Muskingum, Noble, Tuscarawas	818 Boulevard Dover, OH 44622	(216) 343-3355
East Shore	Geauga, Lake	8870 Mentor Avenue Mentor, OH 44060	(216) 255-3679, 8454 or 6016
Hopewell	Adams, Brown, Clinton, Fayette, Highland	5799 West New Market Road Hillsboro, OH 45133	(513) 393-1904
Lincoln Way	Columbiana, Stark, Wayne	1450 West Main Street Louisville, OH 44641	(216) 875-2423, 2527, 3286 or 9996
Miami Valley	Clark, Darke, Greene, Miami, Montgomery, Preble	1150 Beatrice Drive Dayton, OH 45404	(513) 236-9965
Mid-Eastern Ohio	Medina, Portage, Summit	65 Steiner Avenue Akron, OH 44301	(216) 434-3481
North Central Ohio	Ashland, Crawford, Knox, Marion, Morrow, Richland, Wyandot	791 Williamsburg Drive Galion, OH 44833	(419) 468-6447
North East Ohio	Ashtabula, Mahoning, Trumbull	409 Harmon Street, NW Warren, OH 44483	(216) 395-0311
Northern Ohio	Erie, Huron, Lorain	15233 Route 58 South Oberlin, OH 44074	(216) 775-2286
Northwest Ohio	Defiance, Fulton, Hancock, Henry, Lucas, Ottawa, Paulding, Putnam, Sandusky, Seneca, Van Wert, Williams, Wood	10142 Dowling Road, RR #2 Bowling Green, OH 43402	(419) 833-6761, 6771 or 6781
Pilasco-Ross	Lawrence, Pike, Ross, Scioto	411 Court Street Portsmouth, OH 45662	(614) 354-4526
Southeastern Ohio	Athens, Gallis, Hocking, Jackson, Meigs, Monroe, Morgan, Perry, Vinton, Washington	507 Richland Avenue Athens, OH 45701	(614) 594-4235
Southwestern Ohio	Butler, Clermont, Hamilton, Warren	415 Harman Street Cincinnati, Ohio 45219	(513) 241-8641, 8642, 8643 or 8644
West Central Ohio	Allen, Auglaize, Champaign, Hardin, Logan, Mercer, Shelby	RR #6, Box A-3 North Dixie Highway Wapakoneta, OH 45895	(419) 738-9224, 9225

Appendix D
Resources for Evaluation

STANDARDIZED TESTS FOR USE WITH PRESCHOOL HANDICAPPED CHILDREN

Test Instrument	Author	Publisher	Ages	Comments
Adaptive Behavior Scale	Nihera, Foster, Shellas & Leland	American Association on Mental Deficiency	3 years-adult	Percentile ranks on 24 scales obtained by MR population. Measure of social competency. Easy to administer, scoring difficult. Most useful for children below age 12 with limited cognitive ability.
Assessment of Children's Language Comprehension	Foster, Giddan & Stark	Consulting Psychologists Press	3-7 years	Test uses core vocabulary of 50 common words combined in 1, 2, 3, and 4 element phrases. Elements are agents, actions, relations, objects, and attributes. Training items are included. Mean scores on 4 subtests by 6 month intervals and by sex are available. Group form available for preliminary screening of very young children. Scores of children diagnosed as neurologically or educationally handicapped provided for comparison.
Bangs Vocabulary Comprehension Scale	Bangs & Garrett	Teaching Resources	1 month-3 years	Comprehension and expression of oral language measured in developmental age scores. Also provides measure of skill in problem-solving, social/personal, and motor development.
Battelle Developmental Inventory	Guidubaldi, Newborg, Wnek & Stock	Walker Publishing Company	Birth-8 years	Test provides developmental age scores in 5 domains: cognitive, communication, gross and fine motor, personal-social, and adaptive. Provides alternate administrative procedures for various handicapping conditions. A variety of assessment methods are used including structured items, observation, and parent report. Originally developed as evaluation tool for HCEEP programs. Offers much potential as ongoing measure of pupil progress. Especially useful for children with various handicapping conditions, because of special administration procedures.
Basic School Skills Inventory	Goodman & Hammill	Edmark	5-7 years	Provides standard scores in areas related to academic success, including self-help, handwriting, oral communication, reading readiness, number readiness, and classroom behavior.
Bayley Scales of Infant Development	Bayley	Psychological Corporation	2 months-2½ years	Restricted administration — professional diagnostician (psychologist). Mother should be present during evaluation. 45 minutes to administer. Raw scores obtained in mental and motor areas, mental development index, psychomotor development index, 30 behavioral ratings obtained from Infant Behavior Record. Attractive materials, though heavy to transport. Excellent standardization. Broad sampling of infant material. Administration difficult: considerable familiarity with equipment desirable.
Boehm Test of Basic Concepts	Boehm	Psychological Corporation	4-8 years	Test measures children's mastery of concepts considered necessary for achievement in early school years. Concepts include those of space (location, direction), time and quantity. Scores obtained are percentiles by grade. Can be administered by teacher as diagnostic tool. Easy to administer and score. May be too easy for children in grade 2 and late grade 1.

STANDARDIZED TESTS FOR USE WITH PRESCHOOL HANDICAPPED CHILDREN
(continued)

Test Instrument	Author	Publisher	Ages	Comments
Boyd Developmental Progress Scale	Boyd	Inland Counties Regional Center, Inc.	1 month-8 years	Should be administered by professional diagnostician. Test also includes some parent report items. Scale measures the growth and assesses the level of development in these areas: motor skills, communication, and self-sufficiency. No standard scores: items are marked as pass-fail. Easy to administer and score.
Brigance Inventory of Early Development	Brigance	Curriculum Associates, Inc.	Birth-6 years	Test provides norm-referenced and criterion-referenced measure in 98 skill sequences from birth to developmental age of 6 in these areas: psychomotor, self-help, speech and language, general knowledge and comprehension and early academic skills. Useful as ongoing measure of individual pupil progress, as well as tool for developing IEP. Comprehensive tool, can be used in segments as needs dictate. Requires some collection of materials. Especially useful in special education programming.
Bruinicks-Oseretsky Test of Motor Proficiency	Bruinicks	American Guidance Service, Inc.	4½-14½ years	Individually administered test yields estimates of gross motor and fine motor functioning, as well as total score. A short form is available for screening purposes. Requires skilled examiner.
California Preschool Social Competency Scale	Levine, Freeman & Lewis	Consulting Psychologists Press, Inc.	2½-5½ years	To be used by teachers in the context of the preschool program. Ratings are based on cumulative observations of the child in his normal environment. Test consists of 30 items which are representative samples of the critical elements of the preschool child's social functioning. Each item can be scored on four levels of competency. Requires considerable opportunity to observe child in a variety of settings. Useful as teacher-administered instrument.
Callier-Azusa Scale	Stillman	Callier Center for Communication Disorders	Birth to 8 years	To be administered by professional diagnostician (psychologist, special educator). Designed for use with deaf-blind and multiple handicapped children. Test provides measure of skill in these areas: motor development, perceptual development, language development, and socialization. Particularly useful at lower developmental levels.
Carrow Elicited Language Inventory	Carrow	Learning Concepts	3-8 years	Test provides a measure of child's syntactic development. Scores reported in percentiles and stanines. Training guide and training tape can be used with child for remediation.
Cattell Infant Intelligence Scale	Cattell	Psychological Corporation	2 months-2½ years	Test provides a mental age score and IQ for children 3 to 30 months. It can be considered a downward extension of the Stanford-Binet Scale. Scoring is subjective. May not be as current as other available measures. Data obtained (i.e., mental age and IQ) may not provide as much diagnostic information as other devices.

STANDARDIZED TESTS FOR USE WITH PRESCHOOL HANDICAPPED CHILDREN
(continued)

Test Instrument	Author	Publisher	Ages	Comments
Cognitive Skills Assessment Battery	Boehm & Slater	Teachers College Press	Pre-K and K	Individual assessment tool designed to measure skills necessary for success in school. Provides individual skills profile and may be useful in curriculum planning.
Columbia Mental Maturity Scale	Burgemuster, Blum & Large	Harcourt, Brace and World, Inc.	3½-10 years	Especially useful with cerebral palsied or deaf children. Designed especially for use with these children and children with other types of handicaps. Norms may have limited value for educational programming
Detroit Tests of Learning Aptitude	Baker & Leland	Bobbs-Merrill	3-adult	Comprehensive assessment battery provides subtest and total scores and mental age. Demonstrates strengths and weaknesses of specific abilities.
Developmental Potential of Preschool Children	Haeussermann	Grune & Stratton	2-6 years	The Haeussermann technique describes a philosophical approach to the evaluation of young children which is thorough, on-going, and developmentally oriented. Originally developed for use with cerebral palsied populations. Especially useful with multi-handicapped children. A comprehensive structured interview is used by a psychologist or professional diagnostician to determine child's functioning in these areas: physical functioning; sensory intactness and sensory behavior; self-awareness, self-concept, body image; intellectual functioning; emotional-social behavior.
Goldman-Fristoe-Woodcock Test of Auditory Discrimination	Goldman, Fristoe Woodcock	American Guidance Service, Inc.	4-adult	Individually administered instrument which uses pre-recorded stimuli and pointing response to evaluate auditory discrimination in quiet and noise conditions. Reports standard and percentile scores.
Hiskey-Nebraska Test of Learning Aptitude	Hiskey	Dr. Marshal S. Hiskey	3-16 years	Administered by professional diagnostician. Non-verbal, untimed test most often used with hearing impaired children. Pantomime and practice exercises are included to increase comprehension of directions. Measures learning aptitude on the basis of 12 subtests: puzzle blocks, block patterns, picture analogies, spatial reasoning, bead patterns, memory for color, picture association, picture identification, paper folding, memory for digits, visual attention span, and completion of drawings.
Houston Test for Language Development	Crabtree	Stoelting Publishing Company	6 months-6 years	Test provides a total score, basal and ceiling scores by age. Provides a descriptive measure of child's language via observation (up to age 3) and interaction (ages 3-6). Interaction includes sections on vocabulary, geometric drawings, counting, and a language sample. Reports communication age in months.
Kraner Preschool Math Inventory	Kraner	Learning Concepts	3-6½	Individually administered, untimed test which evaluates mathematics skills and concepts in 7 areas. Although essentially a criterion-referenced instrument, provides some normative information.

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STANDARDIZED TESTS FOR USE WITH PRESCHOOL HANDICAPPED CHILDREN
(continued)

Test Instrument	Author	Publisher	Ages	Comments
Language and Learning Disorders of the Pre-Academic Child	Bangs	Western Psychological Services	1 month-6 years	Should be administered by professional diagnostician (psychologist, language specialist, special educator). Approx. administration time: 75 minutes. Useful for handicapped populations: deaf, mentally retarded, aphasic, emotionally disturbed, brain injured, etc. Designed to provide diagnostic and intervention data. Lengthy Test. Useful as pre-post test measure.
Learning Accomplishment Profile-Diagnostic (LAP-D)	Sanford	Kaplan Press	1-6 years	Criterion-referenced instrument which provides an assessment of the child's skills in these areas: language, fine motor, gross motor, social-emotional, and cognitive. Useful as diagnostic tool to plan and evaluate remedial programs.
McCarthy Scales of Children's Abilities	McCarthy	Psychological Corp.	2½-8½ years	Designed to provide a measure of general intellectual functioning of young children. Eighteen tests are grouped into 6 scales: verbal, perceptual-performance, quantitative, memory, motor, and general cognitive index. Scores obtained are reported as standard scores.
Minnesota Preschool Scale	Goodenough, Maurer & Van Wagenen	American Guidance Service	1½-6 years	Composed of 26 tests designed to provide a measure of intellectual functioning. Three scores obtained: verbal, nonverbal and total. Raw scores may be converted to percentile scores, IQ equivalents, or C scores.
Motor Free Visual Perception Test	Colarusso & Hammill	Academic Therapy Publications	4-8 years	Motor-free test of visual perception includes subtests for visual discrimination, figure ground, spatial relations, visual closure, and visual memory. Scores reported as perceptual ages and perceptual quotients.
Peabody Picture Vocabulary Test	Dunn	American Guidance Service	2½-adult	Individually administered instrument provides a measure of child's receptive language ability.
Pictorial Test of Intelligence	French	Houghton-Mifflin Company	3-8 years	Test is a Binet-type instrument which allows child to respond in multiple-choice fashion. Seven scores derived: picture vocabulary, form discrimination, information, similarities, size and number, immediate recall and total score. Total number correct converted to MA units and deviation IQs. Useful for children with motor or speech handicaps. Good reliability scores reported. Correlates highly with WISC and Stanford-Binet.
Porch Index of Communicative Ability in Children (PICAC)	Porch	Consulting Psychologists Press	2½-adult	Test provides a measure of communicative competence. Ten objectives facilitate comparisons across modalities. Child responds orally, with gestures, and by drawing. Function scores obtained in these areas: verbal gestural, reading, verbal description, auditory, verbal naming and reading backwards (decoding). Test is sensitive to changes over time, and can be given frequently without distorting scores. Publisher suggests extensive practice necessary for maximum benefit and recommends users attend special training workshops.

STANDARDIZED TESTS FOR USE WITH PRESCHOOL HANDICAPPED CHILDREN
(continued)

Test Instrument	Author	Publisher	Ages	Comments
Preschool Inventory	Caldwell	Educational Testing Service	2-5 years	Pinpoints verbal strengths and weaknesses of young children necessary for success in educational settings. Provides a profile of child's language designed to facilitate prescriptive teaching.
Preschool Language Assessment Instrument	Blank, Rose & Berlin	Grune & Stratton, Inc.	2-5 years	Pinpoints verbal strengths and weaknesses of young children necessary for success in educational settings. Provides a profile of child's language designed to facilitate prescriptive teaching.
Preschool Language Scale	Zimmerman, Steiner & Evatt	Charles E. Merrill Publishing Company	1½-7 years	Provides age and quotient scores for auditory comprehension, verbal ability, and total score. Supplementary articulation section included.
Receptive-Expressive Emergent Language Scale (REEL)	Bzoch & League	University Park Press	1 month-3 years	Provides age norms and quotients for receptive language, expressive language, and total score. Rater judgement used as basis for scores.
Smith-Johnson Nonverbal Performance Scale	Smith & Johnson	Western Psychological Services	2-4 years	Test is designed as a measure of intellectual functioning. Fourteen categories of subtests included. Child's performance categorized at above average, below average, or average in comparison with peers of same age and sex.
Stanford-Binet	Terman & Merrill	Riverside Publishing	2-adult	Test designed to obtain a measure of intellectual functioning. Tasks divided by age appropriateness. Scores obtained are reported in terms of mental age and IQ.
Tarc Assessment System	Sailor & Mix	H & H Enterprises, Inc.	3-16 years	Behavior observation by teacher, parent, or other adult close to child used to provide information about child's functioning in areas of self-help, motor, communication, and social development. Observable behaviors used by rater to provide measure of performance. Standardized on institutionalized mentally retarded population.
Test of Basic Experiences	Moss	CTB/McGraw Hill	3-7 years	Test provides a measure of academic concepts. Scores reported as stanines, percentiles, and standard scores. Areas tapped include language, mathematics, science, social studies, and general concepts. May be used as screening device or for placement.
Test of Early Learning Skills	Somwaru	Scholastic Testing Service, Inc.	3½-5½ years	Individually administered measure of cognitive skills (thinking, language, and number skills). Obtains developmental age.
Utah Test of Language Development	Mecham, Jex & Jones	Communication Research Associates, Inc.	9 months-16 years	Measures expressive and receptive language skills through use of verbal and non-verbal items.
Wechsler Preschool and Primary Scale of Intelligence (WPPSI)	Wechsler	Psychological Corp.	3½-6½ years	Test provides a measure of intellectual functioning. Scores obtained reported in IQ (verbal, performance, and total). Standard scores reported for subtests provide some information about strengths and weaknesses.

Appendix E
Resources for Placement

ELIGIBILITY FOR PRESCHOOL MULTI-HANDICAPPED PROGRAM

Eligibility for the Early Childhood/Special Education Program of _____ City Schools will be based on Standards for Special Education of the State of Ohio; these standards for the specific handicapping area in which the program is funded, require the following eligibility criteria:

1. Each child will have a multi-factored evaluation prior to initial placement which will include these areas:

   a. physical examination
   b. cognitive functioning
   c. vision
   d. hearing
   e. motor abilities
   f. academic performance
   g. adaptive behavior
   h. communicative abilities

2. Each child shall exhibit two or more of the following handicaps:

   a. deaf or hard of hearing
   b. deaf-blind
   c. developmentally handicapped
   d. orthopedically handicapped
   e. other health impaired
   f. severe behavior handicapped
   g. speech handicapped
   h. visually handicapped

AND

moderate, severe or profound deficits in communication or adaptive behavior

OR

A moderate, severe, or profound developmental handicap with severe or profound deficits in socialization, communication, or adaptive behavior.

3. Children who are eligible for entrance to the Early Childhood/Special Education Program must be between ages of 3 and 5 at the time of initial placement.

HEADSTART REFERRAL FORM

Referral of suspected handicapped child to school district of residence.

Name of child: _____ Birthdate: _____

Present Address: _____

Name of Parent/Guardian: _____ Phone: _____

Address of Parent/Guardian: _____

Name of person making this referral: _____ Position: _____

Agency Name: _____ Address: _____ Phone _____

School district of residence: _____

Handicapping condition

_____ blind/visually impaired

_____ mentally retarded

_____ deaf/hearing impaired

_____ emotionally disturbed

_____ orthopedically handicapped

_____ speech/language handicap

_____ other health impaired

_____ other, please specify

Return form at time of identification, regardless of child's age, to:

Child Find Coordinator: _____

School District Name: _____

Address: _____ City: _____ State: _____

Telephone Number: _____

Signed _____

Date _____

Appendix F
Staff Training

FORMER EMPLOYER ASSESSMENT FORM

Employee's Name _____ Place of Employment _____

Employer's Name _____ Position _____

	Yes	No	NA
1. Demonstrates knowledge of early child growth and development			
2. Demonstrates knowledge and understanding of the early childhood learning environment			
3. Demonstrates knowledge of handicapping condition			
4. Demonstrates knowledge and understanding of the evaluation process for young handicapped children			
5. Demonstrates an expertise in the implementation of programs for educational intervention			
6. Demonstrates effective communication skills with parents			
7. Demonstrates a knowledge of community resources for the identification and services to young handicapped preschoolers			
8. Demonstrates a knowledge and understanding of state and federal mandates under P.L. 94-142			

Comments: _____

_____

_____

_____

_____

_____

SELF ASSESSMENT OF BASIC COMPETENCIES

	Competent in this area	Minimal skill in this area	Needs Further Training
1. Demonstrates knowledge of early child growth and development			
a. recognizes developmental milestones			
b. recognizes developmental characteristics for various stages			
c. recognizes typical cognitive functioning at various stages			
d. recognizes typical social-emotional functioning at various stages			
e. recognizes typical motor functioning at various stages			
f. recognizes typical language functioning at various stages			
2. Demonstrates knowledge and understanding of the early childhood learning environment			
a. arranges the physical environment in an organized manner with learning centers			
b. provides a safe environment			
c. provides materials and experiences appropriate for preschoolers			
d. adapts environment for handicapped preschoolers			
3. Demonstrates knowledge of handicapping conditions			
a. demonstrates knowledge of the characteristics of various handicapping conditions			
b. demonstrates knowledge of the effects of handicapping conditions on the functioning of the child in the classroom			
4. Demonstrates knowledge and understanding of the evaluation process for young handicapped children			
a. is familiar with basic evaluation tools			
b. demonstrates competency in using results of evaluation for program planning			
c. familiar with informal assessment techniques			
5. Demonstrates an expertise in the implementation of programs for educational intervention			
a. collects and analyzes data regarding the functioning of individual children			
b. performs task analyses			
c. develops an IEP for each child			
d. formulates appropriate intervention strategies			
e. utilizes effective child management techniques			
f. demonstrates knowledge of special equipment and materials			

SELF ASSESSMENT OF BASIC COMPETENCIES
(continued)

	Competent in this area	Minimal skill in this area	Needs Further Training
6. Demonstrates effective communication skills with parents			
a. assesses and responds to the needs of parents			
b. demonstrates effective interview techniques			
c. works with parents individually and in groups			
7. Demonstrates a knowledge of community resources for the identification of and services to handicapped preschoolers			
a. knows of community resources for preschool handicapped children			
b. makes referrals to appropriate community resources			
c. establishes and maintains liaison with community resources when appropriate			
8. Demonstrates a knowledge and understanding of state and federal mandates under P.L. 94-142			
a. utilizes due process procedures			
b. adheres to the regulations listed in the State Standards for Special Education			

Appendix G
Parent Participation/Education

PARENT NEEDS INVENTORY

Read each statement and circle the answer which best describes your feelings.

Circle your answers according to this scale:

1. I feel strong in this area.
2. I have average knowledge in this area.
3. I am weak in this area.

	Strong area	Average	Weak area
1. I know and can recognize normal speech and language development.	1	2	3
2. I know and can recognize normal child development.	1	2	3
3. I can use everyday activities as learning opportunities for my child.	1	2	3
4 I can set goals for my child which are realistic for my child's abilities.	1	2	3
5. I can set rules and limits for my child's behavior and consistently enforce them.	1	2	3
6. I can find help or special services for my child.	1	2	3
7. I can accept my child as a unique and valuable individual.	1	2	3
8. I understand the disability and special needs resulting from the handicap.	1	2	3
9. I can get other family members involved in the care and education of my child.	1	2	3
10. I can teach the child skills in daily living such as dressing, eating, toilet training and grooming.	1	2	3
11. I am aware of my own feelings about my child and his/her handicap.	1	2	3
12. I am knowledgeable about P.L. 94-142 and parents' rights and responsibilities as related to my child.	1	2	3
13. I understand the evaluation process and what the tests mean.	1	2	3
14. I understand the concept of mainstreaming and its implications for handicapped children.	1	2	3

_____ Yes, I would like to participate in parent education sessions for parents of preschoolers with special needs.

_____ I may be interested. Please send more information.

Name _____ Address _____

Phone _____ City, Zip Code _____

Appendix H
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